

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the First Amended Accusation)
and Petition to Revoke Probation Against:)

LOREN MORGAN, M.D.)

Physician's & Surgeon's)
Certificate No: C-23681)

Respondent)

Case No.: D1-2002-132501

OAH No.: 2011120883

**ORDER OF NON-ADOPTION
OF PROPOSED DECISION**

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted**. A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street, #210, Sacramento, CA 95814 . The telephone number is (916) 498-9288

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-8906
Attention: Richard M. Acosta

Date: May 8, 2014


Dev Gnanadev, M.D., Chair
Panel B

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PROPOSED DECISION

Administrative Law Judge (ALJ) Marilyn A. Woollard, Office of Administrative Hearings (OAH), State of California, heard this matter in Sacramento, California, on October 28 through 31, 2013, and on November 1, 4 through 8 and 18, 2013.

Deputy Attorney General Jannsen Tan appeared on behalf of complainant Linda K. Whitney, Executive Director of the Medical Board of California (Board).

Louis J. Anapolsky and Kurt Hendrickson, Attorneys at Law, represented respondent Loren Morgan, M.D., who was present throughout the hearing.

Oral and documentary evidence was presented. After the conclusion of the evidentiary hearing, the record remained open for written closing arguments. On January 17, 2014, OAH received closing briefs from complainant and respondent, which were marked for identification only, respectively, as Exhibits 50 and MM. The record was then closed and the matter was submitted for decision on January 17, 2014.

FACTUAL FINDINGS

1. *Overview:* Respondent is a 78-year-old physician who has practiced medicine for over 50 years. He began his medical career in 1960 as a physician in the Army Medical Corps, retired in 1974 as a colonel, and practiced as a reservist through 1996. Respondent is certified with the American Board of Surgery and American Board of Plastic Surgery and is a fellow of numerous surgical associations. He specializes in plastic and reconstructive surgery, maxillofacial surgery, and hand surgery. Respondent has lived in Chico since 1975. He has privileges at the Oroville Hospital and he independently maintains an active

surgical practice at his ambulatory care center in Chico. In 2008, respondent's license was disciplined by the Board. He was placed on probation for five years, subject to conditions that included participation and successful completion of the Physician Assessment and Clinical Education Program (PACE) offered at the University of California, San Diego School of Medicine.

In September 2009, respondent successfully completed PACE, which recommended that he undergo a complete neuropsychological evaluation to rule out any cognitive impairment in light of his poor score on the Microcog Cognitive Screening Test. In May 2010, respondent was evaluated by John A. Shaffer, M.D., a neurologist and psychiatrist, who found no clinically-significant cognitive impairment. The Board then realized that PACE had recommended a neuropsychological evaluation, not a neurological evaluation. In July 2010 and April 2011, respondent was evaluated by neuropsychologists, Karen Bronk Froming, Ph.D., and Eugene P. Roeder, Ph.D., each of whom concluded respondent suffered a cognitive impairment that affected his ability to safely practice medicine. Thereafter, the Oroville Hospital investigated the Board's concerns about respondent's capacities and ultimately determined he was safe to practice. In December 2010, respondent was elected Chief of Surgery at Oroville Hospital, and he has now completed this one-year position.

In June 2011, complainant's Petition for an Interim Suspension Order was denied. Thereafter, on November 30, 2011 and December 28, 2012, respectively, complainant filed an Accusation/First Amended Accusation and Petition to Revoke Probation. As amended, complainant seeks to revoke respondent's license based on allegations of gross negligence, repeated negligent acts, failure to maintain adequate records, incompetence and mental or physical illness affecting competence to safely practice.

2. *Licensure:* Respondent received his medical training in Colorado and became licensed to practice medicine in Colorado on July 31, 1961 (License No. 13840). On December 12, 1961, Board issued Physician's and Surgeon's Certificate Number C23681 to respondent and this California license remains current.

3. *Prior Discipline:* On July 11, 2002, complainant filed an Accusation against respondent, which was amended on September 28, 2004, and July 13, 2005. (OAH Case No. 2008010402; Case No. 16 2002 132501.) In the 2005 Second Amended Accusation, complainant alleged seven causes for discipline pursuant to various provisions of the Business and Professions Code. These charges were based on respondent's out-of-state discipline by the Colorado Medical Board in 2002, based on conduct in 1989, and his treatment of patients in 1998, 2000 and 2002.

Stipulated Settlement: In July 2008, respondent entered into a Stipulated Settlement with the Board, pursuant to which he did "not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations of unprofessional conduct presented in the First, Fourth, and Fifth Causes for Discipline and the allegations of repeated negligence set out in the Sixth and Seventh Causes for Discipline contained in the Second Amended Accusation, No. 16 2002 132501." Respondent did not

admit the truth of these allegations and did not agree that the Board could establish *prima facie* evidence of the allegations involving sexual misconduct.

2008 Board Decision: On September 12, 2008, the Board adopted the Stipulated Settlement as its Decision and Order, effective on October 14, 2008. Respondent's license was revoked and he was placed on five years of probation, conditioned on compliance with standard and special probationary orders. Pursuant to this Decision, respondent's probation was scheduled to terminate on or about October 13, 2013.

4. *ISO Petition:* On May 10, 2011, following receipt of Dr. Roeder's neuropsychological evaluation, complainant petitioned for an ex parte interim suspension order (ISO). Respondent was not present on May 10, 2011, but was represented by counsel. The matter was continued and a noticed ISO was heard on May 25 and 26, 2011. In opposition to the petition, respondent testified and submitted various documents, including the May 25, 2011 Declaration of Glenn A. Hammel, Ph.D. who opined that respondent is cognitively intact and does not have a diagnosable, disabling cognitive disorder. By order dated June 9, 2011, complainant's Petition was denied.

5. *Accusation and Petition to Revoke Probation:* On November 30, 2011, complainant filed an Accusation and Petition to Revoke Probation against respondent. Complainant alleged that respondent's ability to practice medicine was impaired within the meaning of Business and Professions Code section 822 (mental or physical illness affecting competence to safely practice) and that his continued treatment of patients constituted unprofessional conduct within the meaning of section 2234, subdivisions (a), (d), and/or (f).¹ Complainant further alleged that respondent's probation should be revoked based upon his failure to pass the neuropsychological examination recommended by the PACE program.

6. Respondent timely filed a Notice of Defense and request for hearing. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500, et seq. The hearing was subsequently continued at complainant's request.

7. *First Amended Accusation and Petition to Revoke Probation:* On December 28, 2012, complainant filed a First Amended Accusation and Petition to Revoke Probation. Complainant re-alleged the factual basis for discipline in the original Accusation as violations of sections 822 and 2234, subdivision (d) (incompetence), and added three additional grounds for discipline under section 2266 and 2234, subdivisions (b) (gross negligence) and (c) (repeated negligent acts), as specifically described below.

¹ Unless otherwise indicated, all undesignated statutory references are to the Business and Professions Code.

I. Respondent's Alleged Repeated Negligent Acts at Ambulatory Surgical Center

8. Complainant alleged that respondent engaged in repeated negligent acts within the meaning of section 2234, subdivision (c), because: (1) his ambulatory care surgical center (facility) was not a sanitary environment for the provision of surgical services and the facility's anesthesia machine was not in good working order; (2) the facility's registered nurse (RN) did not know how to use the anesthesia machine and was not a Certified Registered Nurse Anesthetist (CRNA); and (3) respondent failed to ensure that medications were provided to patients in a safe manner and failed to properly monitor patients under anesthesia.

Issues Related to Conditions at Respondent's Facility

9. Respondent's facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a non-profit national accrediting organization for hospitals and ambulatory care centers, through approximately January 2015. JCAHO is one of the accrediting agencies approved by the Board to accredit outpatient surgery centers in California. Respondent's facility was initially accredited by JCAHO in 2005. The facility employs one RN, respondent's wife, Marilyn Morgan.

10. On July 27, 2007, the Department of Health and Human Service (DHHS), Centers for Medicare and Medicaid Services (CMS), notified respondent that it had accepted his agreement to participate as an ambulatory surgery center in the Medicare program. He was advised that his continued participation depended on his ability to maintain compliance with the federal regulations in 42 C.F.R. Part 416. Respondent maintained this agreement through late 2011.

11. On October 6 and 7, 2011, JCAHO conducted "an unannounced full resurvey" of the facility "for the purposes of assessing compliance with the Medicare conditions for ambulatory surgical centers." The facility received "Requirements for Improvement," indicating a need for corrective action in certain areas, which respondent cleared in January 2012.

12. Following this resurvey, the California Department of Public Health (CDPH) conducted a validation survey (survey) of the facility. This survey was conducted as one of the random surveys required by CMS, within 60 days of JCAHO certification. The survey at respondent's facility occurred on November 14, 15, 16 and 22, 2011, by CDPH health facility evaluator nurse Paula Pezzotti Evans and medical consultant Charles Arthur Derby, M.D. (the inspectors). The role of the inspectors was to determine respondent's compliance with all federal regulations for an ambulatory surgery center. The inspectors were not aware of JCAHO's recent findings.²

² For example, the inspectors did not know that the JCAHO inspection found areas of non-compliance by the facility's practice of storing some items under the operating room's open sink; or that JCAHO did not find non-compliance by the presence of that open sink.

13. During the survey, the inspectors reviewed patient files, spoke to patients, observed surgeries and interviewed staff. Concerns were noted regarding documentation and use of Monitored Care Anesthesia (MAC), specifically Diprivan/Propofol (hereafter, Propofol). The inspectors noted that the facility's only nurse is RN Morgan, who had Advanced Cardiovascular Life Support certification but was not a CRNA. On November 14, 2011, the inspectors declared an "immediate jeopardy" based on the facility's use of Propofol; other immediate jeopardies were issued the following day based on environmental conditions that could endanger patient safety. Based on this declaration, all covered surgeries had to stop until an acceptable plan of correction was received. Ms. Evans testified that, by the third day of the survey, November 16, 2011, respondent became "rather belligerent almost in trying to explain that what we were asking for didn't make sense." In his testimony, Dr. Derby acknowledged that it was normal for a physician and his staff to feel stressed on the third day of an unscheduled survey conducted during business hours.

14. As reflected in the testimony of Dr. Derby and respondent, respondent agreed to correct each of the environmental issues identified and he immediately agreed to stop using Propofol. Respondent provided Dr. Derby with two written confirmations to this effect. In the second writing, dated November 15, 2011, respondent acknowledged non-compliant use of Propofol, stated that the facility had immediately stopped use of this drug, would remove it from the facility, and represented that an RN would be dedicated to observing patients during surgical use of "local and blocks." At some point, Dr. Derby informed respondent that his continued participation in the Medicare program was voluntary. Because efforts to clear the immediate jeopardy were unsuccessful, on November 16, 2011, respondent wrote to CMS, with his "request to be withdrawn from the Medicare Certification Program," as of that date.³

15. Based on the inspectors' findings set forth in their Statement of Deficiencies, the First Amended Accusation alleged that respondent engaged in repeated negligent acts regarding environmental issues that pose a risk of contamination to the operating room. Specifically, (1) there was a carpeted common hallway used by patients and facility staff to enter the operating room and patient exam rooms; (2) there was an open sink in the operating room; (3) the operating room and other areas of the office lacked separate temperature and humidity controls; and (4) there was a lack of systems to monitor temperature and humidity in the operating room. (Par. 16).⁴ In addition, the anesthesia machine in the operating room was not operational and had not been serviced since October 2010, when it was noted to lack a vacuum and to have expired oxygen in its tanks; and RN Morgan indicated she did not know how to use the machine. (Par. 17). Respondent had no emergency transfer agreements and no mechanism for credentialing professional staff or for peer review of care provided at the facility. (Par. 18.)

³ Dr. Derby testified that this letter was adequate to lift the immediate jeopardy.

⁴ All paragraph references are to the First Amended Accusation.

16. On November 21, 2011, respondent filed a “Response to Immediate Jeopardy” with CDPH, setting forth corrective measures (i.e., he agreed to install monitoring devices on the existing dedicated ventilation system in the operating room and to cover the open sink). Respondent verified the presence of two mechanical ventilators; reiterated that the facility had stopped use of Propofol; and advised that respondent had secured two credentialed anesthesiologists and two CRNAs who were available to perform anesthesia in the facility on contract as needed.

17. On November 22, 2011, Ms. Evans returned to the facility, but respondent was not available due to previously-arranged international travel. The receptionist denied her access to the facility, and said that there was construction work going on in the operating room. Ms. Evans was not able to verify respondent’s corrections to the facility.

18. On November 23, 2011, CMS notified respondent that his facility no longer met requirements for participation as an ambulatory surgery center with the Medicare program and that his Medicare agreement would be terminated effective December 8, 2011. It summarized that the facility was found to be in violation of Conditions for Coverage, set forth in federal regulations for Environment and Pharmaceutical Services (respectively, 42 C.F.R. §§ 416.44 and 416.48), and that these violations were determined to pose immediate jeopardy to the health and safety of patients.

19. On January 17, 2012, JCAHO advised respondent that his facility was fully accredited, effective January 2, 2012, based on evidence he had submitted of standards compliance in response to the October 2011 inspection. JCAHO informed respondent that it did not recommend his facility for continued Medicare certification, based on his recent termination from that program.

On January 17, 2012, CDPH sent a referral to the Board about respondent’s facility, noting the CMS determination and indicating that these “violations involved the use of Propofol in an unsafe and dangerous manner [which] led to CMS revoking his Certification as a risk to the health and safety of patients.”

20. *Dr. Johnson’s Expert Report and Testimony:* Debra Johnson, M.D., obtained her medical degree from Stanford in 1981 and her California medical license in 1982. She completed her residency at Stanford University Hospital in general and plastic surgery in 1989, and then completed fellowships in aesthetic surgery (Barcelona, Spain) and in hand and microsurgery (Paris, France). Dr. Johnson has practiced as a general plastic surgeon at the Plastic Surgery Center in Sacramento since 1989. In 1991, she became a Diplomate of the American Board of Plastic Surgery and remains so currently. Among her other professional activities, Dr. Johnson is the director of the Cleft Lip and Palate Program. Dr. Johnson is a plastic surgery expert reviewer for Medical Boards of California and Alaska.

21. Dr. Johnson reviewed documents pertaining to the validation survey and respondent’s loss of Medicare certification. She did not provide expert testimony regarding

the standard of care for each of the facility's specific alleged environmental problems. In her September 17, 2012 report, Dr. Johnson described the standard of practice as follows:

Medicare certification requires compliance with the rules and regulations regarding ambulatory surgical facilities. These regulations concern the physical layout of the facility, airflow and humidity, pharmaceutical care and safety, and patient care and safety. In this case, it appears that Dr. Morgan's facility should never have qualified for Medicare/MediCal certification in the first place. His office did not meet the physical plant requirements at a basic level.

Dr. Morgan's office-based operatory had passed inspection by JCAHO, and was reaccredited. The patient safety issues identified by JCAHO at that inspection were corrected. Dr. Morgan had been complying with the accrediting body.

There was no deviation from the standard of practice.

In her testimony, Dr. Johnson added that she believed respondent's facility may have been "grandfathered in" because it was likely built before the Medicare regulations came into effect. She further testified that the inspectors' temperature and humidity concerns were not based on regulation, did not pose a grave danger to patient safety, and that respondent did not deviate from the standard of practice. Dr. Johnson felt it was "unconscionable" for the inspectors to demand entry to the facility on November 22, 2011, when the principal owner was not present. She opined that the inspectors' behavior during the survey "appears to have been adversarial."⁵ While respondent did have instances of simple departures from the standard of care, she concluded that "nothing rose to the level of 'grave threat to patient safety.'"

22. Regarding respondent's alleged failure to have a transfer agreement to Enloe Hospital, Dr. Johnson found no deviation from the standard of practice. She noted that respondent had hospital privileges at Oroville Hospital. Because accreditation requires active privileges at a hospital or a transfer agreement, respondent was not required to have a transfer agreement.

23. Respondent testified that these conditions had been brought into compliance. For example, respondent corrected the absence of separate temperature and humidity controls; installed a Magna helix to address humidity; and had closed the open sink. He described the special cleaning process used for the hallway carpet prior to each surgery and testified that the maintenance records for the anesthesia machine were now up to date. This testimony was undisputed.

⁵ This was consistent with RN Morgan's testimony.

24. There was insufficient evidence to establish repeated negligent acts based on the facts alleged in the First Amended Accusation at paragraphs 16, 17, and/or 18.

Issues Related to Respondent's Use of Propofol at the Facility

25. Dr. Johnson testified that Propofol is a drug that has been used for deep sedation since the early 1990s. It places patients into a deeply sedated, dreamlike state so they can tolerate intubation for general anesthesia and it is also used as a constant infusion to keep patients deeply sedated during anesthesia. Because it induces deep sedation, Propofol causes respiratory depression and patients can either slow or stop breathing.

For this reason, the FDA has issued a warning regarding the use of Propofol, which has been placed on manufacturers' labels. The warning provides:

Propofol should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure. **Patients should be continuously monitored and facilities for maintenance of a patent airway, artificial ventilation, and oxygen enrichment and circulatory resuscitation must be immediately available.** (Bold in original.)

26. In her expert report, Dr. Johnson indicated that "the use of Propofol should be limited to those with advanced airway management skills, and not also involved in the surgical care of the patient." Due to Propofol's ability to cause respiratory arrest, advanced airway management skills are needed to quickly control the patient's ventilation, and all available equipment must be ready to maintain the patient's breathing until emergency services can be obtained. Dr. Johnson testified that the standard of care includes following FDA warnings.

27. Based on her review of documents regarding respondent's practice and patients, Dr. Johnson determined that respondent used Propofol in a manner that was inconsistent with this warning. Respondent used the drug at the same time that he performed surgical procedures. RN Morgan was the person who administered Propofol to patients under his direction; however, she is not a CRNA. Both respondent and RN Morgan have Advanced Cardiac Life Support (ACLS) training and they believed this was sufficient. Neither, to her knowledge, had advanced airway management skills. While ACLS training includes airway management training, it is not "advanced" airway management training. Even if respondent had appropriate training, he could not administer Propofol while he is the surgeon.

From her review of patient records, Dr. Johnson noted that respondent has used Propofol successfully since 1991. The warning label has only been in effect for the past five to eight years. Consequently, because respondent was well-experienced in its use, with no records that indicated negative patient reactions, Dr. Johnson considered this to be a simple

departure from the standard of care.⁶ However, from a medical-legal standpoint, she opined that respondent's practice was not defensible. As soon as respondent learned that ACLS certification was not sufficient, he agreed to terminate his use of Propofol in his outpatient facility.⁷ Dr. Johnson concluded that respondent's conduct was "a simple departure from the standard of care that has been corrected."

28. It was established that respondent and RN Morgan are ACLS Providers. Their current ACLS certification is valid through May 31, 2015.

29. Respondent testified about his training in and use of anesthesia, in his military career which included experience as a trauma surgeon in Vietnam, and in his private practice. In 2004 and 2005, respondent received training from Oroville's Chief of Anesthesia Services, Bruce Reiman, M.D.⁸

There was no dispute that, prior to the validation survey, respondent used Propofol while performing various surgeries with the assistance of RN Morgan. Respondent described his standard procedure when he used Propofol at his facility. He began such surgeries by personally administering Propofol via an automatic, regulated pain pump, approved by the manufacturer, which kept the patient just below consciousness. The amount used varied according to each patient's specific condition. This continuous low flow was augmented during the surgery by administering small bolus doses either personally or by having RN Morgan do so at his direction.

30. Complainant specifically alleged that respondent used Propofol while performing surgery and that he engaged in other repeated negligent acts during the procedures described below.

⁶ Dr. Johnson would consider this an extreme departure for a new plastic surgeon.

⁷ Respondent does not administer Propofol or any other anesthesia during surgery at Oroville Hospital.

⁸ In August 2005, after observing respondent's surgeries over several months, Dr. Reiman issued a letter "certifying" that respondent "is competent in the conduct of I.V. Sedation and use of a [Laryngeal Mask Airway] L.M.A." Dr. Reiman also observed RN Morgan in the role of "Circulator and Airway Management Supervisor" and found her competent in the administration of various I.V. agents including Propofol, Ketalar, Versed and Fentanyl. He opined that RN Morgan "is qualified to track patient ventilation and various patient-monitoring systems."

Dr. Johnson described an LMA as a device used to control an airway which is placed in the back of the throat. Its inflated diaphragm blocks the esophagus to insure that air goes only into the lungs and not into the stomach.

31. *Patient W.S. (June 20, 2011 facelift)*: Complainant alleged that, during this June 20, 2011 procedure on W.S., the patient's history and physical condition was not re-evaluated pre-operatively by respondent; and that MAC anesthesia clearance was performed by RN Morgan, outside her scope of practice. (Par. 19.)

During this surgery, W.S. received medications, including Propofol, Fentanyl, and Versed. These were administered by RN Morgan pursuant to respondent's standard procedure. Ms. Evans testified that, during the survey, RN Morgan confirmed that she usually did the ASA classification evaluations, which is the pre-surgical anesthesia evaluation indicating the patient's anesthesia risk category (from 1 to a high of 4).

32. *Patient J.F. (November 1, 2011 breast reconstruction surgery)*: Complainant alleged that J.F. was administered Propofol by RN Morgan. (Par. 20.)

J.F. has been respondent's patient since at least 1991. Respondent testified that he administer Propofol to J.F. during her 1991 surgery for removal of breast implants. He explained that the circular he reviewed for this surgery did not indicate that the surgeon could not administer the medication.

Respondent testified that he also administered Propofol during J.F.'s January 31, 2011 surgery (release bilateral breast contraction and exchange) and her November 1, 2011 surgery (removal of breast implants, pain pump and biopsy), according to his standard procedure (directly and via RN Morgan). Respondent noted that one month before this latter surgery, a JCAHO anesthesiologist had observed respondent use Propofol during surgery, but made no adverse comments about its use.

33. *Patient E.B. (November 14, 2011 bilateral breast lift and implant replacement)*. Ms. Evans testified that during her observation of this surgery, she saw RN Morgan pre-draw syringes of medications without a prior order from a physician. E.B. received Propofol from a pump and RN Morgan also gave E.B. seven doses of Propofol by bolus, on respondent's verbal order. E.B. received a total of 2,740 mg of Propofol during this four-hour procedure and "was at risk of overdose of anesthesia because both a pump and injections were being used together" (Par. 22.)⁹ Ms. Evans agreed that she was not qualified to determine if this was an excessive amount of Propofol.

Ms. Evans further testified that RN Morgan administered the Propofol, while also performing other duties. Consequently, no one was solely responsible for monitoring E.B.'s airway breathing and circulation, placing her at risk of anesthesia complications. (Par. 23.) Ms. Evans heard respondent give RN Morgan verbal orders to give some of the boluses; however, there was no documentation of a verbal or written order.

⁹ Ms. Evans testified that the Propofol packet insert also said that bolus doses should not be administered. Dr. Johnson did not address this in either her report or testimony.

Respondent testified that he performed various surgeries on E.B. in which he used Propofol. During the November 2011 surgery, he did so according to his standard procedure.

34. *Patient V.F. (November 14, 2011 lip cyst removal):* Ms. Evans testified that she observed this surgery and saw respondent give V.F. local anesthesia, a combination of Versed and Lidocain, by direct injection into the vein, with no Hep-Lock in place. This posed a safety concern for quick response if the patient had an allergic reaction and required quick administration of intravenous (IV) fluids or medications. (Par. 21.)

Dr. Johnson reported she could not judge the veracity of Ms. Evan's claim and she did not have access to this patient's record. During her testimony, Dr. Johnson indicated that it is a standard of care to "maintain access, intravenous access," when giving any intravenous medications. If respondent had done so, it would be a simple departure from the standard of care. She noted that, in his Board interview, respondent denied not using a Hep-Lock, which is his standard practice when using intravenous medications. Before doing this, respondent administered a local injection into the skin with a small gauge needle. Dr. Johnson elaborated that, in light of respondent's denial that he did this, she chose not to believe Nurse Evans because she "felt that the CDPH evaluation was a little over the top."

35. Based on respondent's admitted administration of Propofol to patients W.S., J.F. and E.B. in 2011 using his standard practice described in Factual Finding 29, respondent engaged in repeated negligent acts as outlined in the First Amended Accusation at Paragraphs 19, 20, 22 and 23.

II. Respondent's Alleged Failure to Maintain Adequate and Accurate Patient Records

36. Complainant alleged that respondent engaged in unprofessional conduct within the meaning of section 2266 in the following ways: (1) by listing inaccurate patient discharge times; (2) by failing to note physician orders, medication administration times, intra-operative vital signs, pain assessments, discharge score or criteria; and/or (3) by discharging patients with a pain pump, but with no note of instructions. These allegations pertained to the surgical records for W.S., J.F., and E.B.

37. *Patient W.S. (Par. 27):* Complainant alleged that, during the June 20, 2011 procedure, there were no physician orders documenting IV medications; the times medications were administered was not documented; the discharge assessment was eight minutes after (6:52 p.m.) patient was discharged (6:44 p.m.); and a patient discharge score was not noted in the records.

38. *Patient J.F. (Par. 28):* Complainant alleged that, during the November 1, 2011 procedure, there were no physician orders noted in the chart; the times medications were administered was not documented; intra-operative vital signs were not noted; there was no pain assessment or discharge score or criteria noted; and there were no notes that discharge instructions on use of a pain pump were given.

39. *Patient E.B. (Par. 29):* Complainant alleged that respondent failed to update E.B.'s August 25, 2011 history and physical prior to her November 14, 2011 surgery; that she was discharged with a pain pump for her left breast with no record that instructions on use of the pump were given; and that there was no record of discharge criteria before release.

Dr. Derby criticized the adequacy of respondent's August 25, 2011 patient history and physical examination for E.B. He testified that respondent's patient examination was incomplete and that his SOAP notes failed to document a full examination or vital signs. In his opinion, the November 14, 2011 Recovery Record was not specific enough and failed to indicate how the patient was responding. The record, signed by RN Morgan, did not indicate who administered the Propofol, Versed, Fentanyl and Ketalar.

40. Dr. Johnson reviewed the CDPH inspectors' concerns about "documentation of patients meeting discharge criteria, and ... timing of medications delivered," as well as the patient records for W.S., J.F. and E.B. In her expert report, Dr. Johnson broadly addressed these concerns and noted that respondent had updated the physical examination for E.B. in his operative record.¹⁰ She concluded that "the other documentation errors are a simple departure from the standard of practice."

41. Respondent described his standard practice for discharging surgical patients. He personally walks each patient outside to their vehicle. Respondent believes that, if a patient is unable to walk to his/her vehicle after surgery, they should not be discharged.

42. Regarding documentation of discharge criteria, Dr. Johnson testified that there were instances where patients met discharge criteria almost immediately in their recovery, but were discharged half an hour to 45 minutes later. In her opinion, the CHPD inspectors' criticism that respondent did not again document that patients met discharge criteria-- "despite having not received any further medication that would reduce their level of consciousness"-- was "a little persnickety."

43. Dr. Johnson testified that the standard of care when drugs are administered is that the time and date of administration should be documented. This is important for continuity of care, it protects patients from potential overdose, and it helps to anticipate how the patient will react. Dr. Johnson found several simple departures from this standard of care in respondent's patient records for these surgeries.

44. Regarding discharge instructions for the pain pump, Dr. Johnson reported that this pump is a passive system for providing low-dose local anesthesia to the surgical wound over several days. "The system is self-contained and automatic. The patients were informed of the pain pump preoperatively, as documented in the record. No instructions were necessary at discharge. There was no violation of the standard of practice."

¹⁰ Dr. Johnson did not identify the patient in her report, but in testimony addressed this concern regarding E.B.

45. Respondent's record-keeping style is terse, apparently based on the belief that only he and RN Morgan are likely to rely on those records. His practice involves the use of standing and verbal orders for medication administration that are not documented. Based on Dr. Johnson's expert review, it is concluded that respondent failed to maintain adequate and accurate records for patients W.S. and J.F.

III. Respondent's Alleged Gross Negligence: Interference with Emergency Personnel

46. Complainant alleged respondent is subject to discipline for gross negligence within the meaning of section 2234, subdivision (b), based on his conduct of interfering with the activities of emergency personnel responding by ambulance to the home of his post-surgical patient V.A. Respondent's conduct was alleged to have "delayed their care and treatment of an acutely ill patient" and caused "a significant transport delay to the appropriate medical facility."

47. The events leading to these allegations occurred on January 11, 2012. Earlier that afternoon at the facility, with the assistance of a CRNA, respondent performed abdominoplasty surgery on patient V.A. and removed a 14 pound pannus. VA was then placed into special compression garments to protect her incision. She was released to the care of her husband B.A. with a wound vacuum (vac), designed to remove blood and serum, and a pain pump with local anesthesia. From prior surgeries, V.A. and B.A. were familiar with using the wound vac.

In the early evening, B.A. called respondent and told him V.A.'s wound vac was malfunctioning. Respondent went to V.A.'s home and was met there by RN Morgan. After seeing V.A. and trying to fix the wound vac, respondent asked B.A. to call 911.

48. On January 11, 2012, at 7:36 p.m., two employees from First Responders Emergency Medical Services (EMS) in Chico responded to the 911 call to V.A.'s home by Code 2 (no lights, no sirens). Aaron Kleinschmidt was the licensed paramedic in charge who primarily interacted with respondent. He was assisted by licensed Emergency Medical Technician (EMT) Donovan Ruttan. They are collectively referred to as "the EMTs."

49. *Timeline:* The timeline of events was recorded in the Patient Care Report prepared by the EMTs shortly after the incident.¹¹ The EMTs first saw V.A. in her bedroom at 7:38 p.m. and transported her by Code 3 ambulance to Enloe Medical Center (Enloe) at 8:03 p.m., 25 minutes after their arrival. The EMTs were not able to take V.A.'s vital signs until 7:53 p.m., 15 minutes after first seeing her.¹²

¹¹Based on these reports, complaints to the Board about respondent's alleged interference were filed by Enloe's Vice President of Medical Affairs, Marcia Nelson, M.D., and by John Poland, Sierra-Sacramento Valley EMS agency.

¹²The timeline in the Patient Care Report was amended by Mr. Kleinschmidt's testimony that the reported time for taking vital signs (7:56 p.m.) was actually the time V.A.

50. The EMTs testified consistently about the events during that call.

Upon their arrival, respondent immediately identified himself as V.A.'s "personal physician," indicated that he had performed an abdominoplasty on her earlier that day and that she was having bleeding due to a wound vac malfunction. B.A. was also present. In Mr. Ruttan's recollection, respondent did not appear to be stressed out or angry. Once in the house, respondent was standing at V.A.'s bedroom door explaining her blood loss. The EMTs did not know whether respondent had already assessed V.A.

Respondent told Mr. Kleinschmidt that V.A. needed to be transported to Oroville Medical Center (OMC) because that was where he had privileges to practice. It appeared that respondent wanted to get V.A. to OMC immediately. OMC was approximately 40 miles away. The EMTs told respondent that the closest, most appropriate facility was Enloe, which was 3.8 miles from V.A.'s home. Mr. Kleinschmidt told respondent that he needed to assess V.A. before making any transportation decision, that transportation to OMC would be facilitated after that, but that the family may be financially responsible for this transport.

51. V.A. was in bed in her bedroom and the EMTs were only able to see her from the bedroom door. She appeared to be pale and diaphoretic. Mr. Kleinschmidt was concerned she might go into shock from loss of blood.¹³ After seeing V.A. and the number of filled wound vac containers, the EMTs estimated that she had probably lost around 1,000 milliliters of blood. When Mr. Kleinschmidt began asking V.A. questions, respondent interrupted, told him to stop asking questions, to get his gurney and "keep moving" to take the patient. Respondent appeared agitated and he blocked the door so the EMTs could not enter and perform an assessment. To appease respondent, the EMTs agreed to get the gurney.

52. On return, the EMTs found V.A. in a collapsed position at the bedroom door with respondent and RN Morgan by her side. Respondent stated he had walked V.A. to the door to "get her going." The EMTs wanted to assess V.A. to ensure she had no injuries from this fall. Respondent again told them to stop questioning, and he blocked them from touching her. Mr. Kleinschmidt asked if respondent had taken V.A.'s blood pressure. Respondent said he had not, but that he had "a recent pulse ox reading." On further questioning, respondent told Mr. Kleinschmidt to stop asking stupid questions and to "keep moving."

was in the ambulance and that he had taken her vital signs approximately three minutes earlier when she was in her minivan.

¹³ Mr. Kleinschmidt was not able to touch V.A. He corrected the Patient Care Report, where he had indicated she was "cool."

53. The gurney did not fit in the bedroom door. V.A. was placed on a chair with wheels and rolled to the living room, where she was placed on the gurney. Respondent appeared upset because the EMTs would not tell him with certainty to which facility they would transport V.A. The EMTs told respondent that they could not honor the request to transport V.A. to OMC because there were too few ambulance units in their area. Respondent told them to hurry up and get V.A. into her minivan where she would be privately transported. Mr. Kleinschmidt told B.A. that he would need to sign an Against Medical Advice (AMA) form. To complete this form, Mr. Kleinschmidt was required to take V.A.'s vital signs. When the EMTs reiterated the need to do this paperwork, respondent became upset. According to Mr. Ruttan, respondent at no point gave them "any opinion as far as his assessment on the patient; or whether or not he had done any vital signs."

54. Respondent grabbed the head of the gurney and began pulling it out of the foyer and onto the front steps of the house, while saying "keep moving and do what I say." Mr. Ruttan was forcefully trying to hold the gurney back at its foot. After being told to leave the equipment alone and that an assessment was needed, respondent told Mr. Kleinschmidt, "I don't care about your job, just keep the patient moving." Respondent then blocked Mr. Kleinschmidt with his body, aggressively standing approximately six to eight inches away from Mr. Kleinschmidt's face, which prevented him from operating the gurney. Based on respondent's behavior, Mr. Ruttan got his radio and was ready to call the police. Respondent continued to tell Mr. Kleinschmidt to listen and to do what he said. Respondent then stepped away from the gurney and made calls on his cell phone.

55. The EMTs then moved V.A. to the front passenger seat of her minivan where her vital signs were first taken. Her pulse was weak and the EMTs were not able to obtain a systolic or diastolic blood pressure reading. Mr. Kleinschmidt told V.A. that her blood pressure was extremely low and that she needed emergency medical care. After he told respondent he would transport V.A. to the closest facility, respondent insisted that she be transported to OMC and said that "we/he" would drive her to the hospital. Mr. Kleinschmidt told V.A. and B.A. that they had a right to make their own decision about the AMA. B.A. seemed unclear what to do. V.A. then said she wanted to go to Enloe by car. After being told she might die if she went by car or to another hospital, V.A. agreed to be transported to Enloe by ambulance. Respondent did not prevent the EMTs from moving V.A. from the minivan to the ambulance. Respondent remained on his cell phone and the EMTs had no further contact with him. After taking her vital signs, Mr. Kleinschmidt believed V.A. had bleeding in her belly, determined that transport was critical and did so with lights and sirens (Code 3).

56. Mr. Kleinschmidt testified that transport to OMC would take approximately 35 to 40 minutes in a Code 2 driving situation (no lights or sirens). Transport to Enloe would take approximately 15 minutes in Code 2 and 10 minutes by Code 3. The standard of care for emergency personnel to spend seeing trauma patients before transporting them is 10 minutes. The EMTs spent 25 minutes on this call.

57. V.A. and B.A. both testified to their recollection of events which was similar to that of the EMTs. V.A. was in and out of consciousness at certain times during the call, and B.A. was not in the bedroom for some of the time that respondent remained there with V.A. V.A. characterized the confrontation between respondent and the EMTs as “a brawl” that her neighbors might hear; her husband said it was “more like a tussle.” B.A. acknowledged that there were discussions about the cost of various transportation options. He also testified that, although he agreed to take V.A. to OMC, respondent never told him that V.A.’s condition was critical. Once they were informed of her condition by the EMTs, V.A. chose to go to Enloe.

58. Respondent testified that he assessed V.A. on his arrival. His focus in his interactions with the EMTs was to keep the patient moving. He and RN Morgan helped V.A. walk toward the bedroom door to facilitate getting her on the gurney then gently laid her on the floor when she passed out.

Respondent has worked with paramedics and EMTs as a trauma surgeon, in the military and in general. Based on this experience, respondent believed he was in charge of V.A.’s care and that the EMTs should comply with his orders. Respondent agreed that he may have raised his voice toward the EMTs, but he clarified that this was only done out of a sense of urgency rather than anger. He made phone calls to OMC to facilitate V.A.’s treatment and he arranged for Dr. Cleek to facilitate V.A.’s medical treatment at Enloe.

59. RN Morgan testified that she observed respondent palpate V.A.’s abdomen, take her pulse, check her eyes and talk to her and that he did not need to use a blood pressure cuff. When respondent finished his assessment, he had B.A. call 911 and they began planning where to go. The issue of affordability for V.A. and B.A. was not unusual and respondent and B.A. discussed costs of various options. The discussion about money got “a little more pointed” once V.A. was on the gurney in the foyer. V.A. was talking so her blood pressure was back up. Once the EMTs told them the cost of transport, there was a discussion about personally driving V.A. to OMC and the EMTs helped her to her minivan. RN Morgan did not hear respondent raise his voice. Throughout the incident, respondent was calm, controlled, and “a leader in charge.” She thought the EMTs were inexperienced and shocked to see a doctor and a nurse at the scene. The EMTs were friendly, but she heard them raise their voices, probably in frustration. Respondent was making phone calls to facilitate V.A.’s admission to OMC or Enloe.

60. Following this incident, V.A. was admitted to Enloe and found to be in shock. She was taken into surgery where Dr. Cleek repaired an arterial bleeder and evacuated a hematoma from her abdomen. V.A. received three units of blood. During this surgery,

V.A. suffered a pneumothorax and received a chest tube, which required her to remain in the hospital for several days. On her release from Enloe, V.A. was treated by respondent for several months, due to problems with her wound healing.¹⁴

In early March 2012, V.A. and B.A. were interviewed by Board investigator Shane Wright. V.A. was last treated by respondent on March 26, 2012, after she reviewed her medical record and believed respondent had made erroneous entries. She then sought treatment elsewhere. V.A. and B.A. later filed a civil action against respondent which mirrors many of the allegations in the First Amended Accusation.

61. *Dr. Johnson's Expert Report and Testimony:* Dr. Johnson reviewed documents provided by the Board regarding these allegations, including V.A.'s medical records and the Patient Reports and incident reports prepared by the EMTs. Based on this review, Dr. Johnson determined that respondent had "impeded the activities of the ambulance personnel, asking them to forgo their own evaluation of the patient in order to get her to the hospital quickly . . . He obstructed the paramedics who were trying to transport [V.A.] out of the home. He was apparently belligerent and physically threatening. When informed that transport to Oroville would be more costly to the patient, the suggestion of transport by private car was raised. The paramedics assisted the patient into her own van, and only then were they able to assess her blood pressure, which was extremely low. The paramedics insisted the patient was at grave risk and needed transport to the nearest facility, which was Enloe . . . Dr. Morgan then acceded to their demands and spoke to Dr. Cleek at Enloe, who accepted care of V.A. on her arrival."

62. *Standard of Practice:* Dr. Johnson reported that:

It is the standard of practice that when emergency services are requested, the emergency personnel be given ready access to evaluate and treat the patient as they see fit. The treating physician should communicate all pertinent information to the emergency personnel, but does not have the right to overrule their judgment. In the face of grave risk, the patient must be transported to the nearest treatment facility.

Dr. Johnson commended respondent for going the V.A.'s home to evaluate her postoperative distress after B.A. called him, noting that there are not many doctors that will make house calls these days. She opined that respondent "quickly realized [V.A.] was in trouble and requested emergency services. However, once the paramedics arrived, he hampered their activities, thus delaying treatment for the patient. This is an **extreme departure** from the standard of practice." (Bold original.) In summary, Dr. Johnson acknowledged that respondent was the "captain of the ship" during the abdominoplasty

¹⁴ Dr. Johnson reported that V.A.'s hematoma from an arterial bleed is a known complication of abdominoplasty and "does not indicate negligence on the part of Dr. Morgan."

procedure and that he was motivated to minimize VA's expenses involved with the complication. Nonetheless, she opined that respondent "overstepped his authority in his interaction with the emergency personnel who responded to his 911 call. His actions could have resulted in a far worse outcome for V.A." Based on her review of the medical records, Dr. Johnson indicated that time was of the essence given V.A. massive loss of blood. On arrival at Enloe, V.A. was in critical condition as hypotensive and in shock.

Regarding respondent's effort to have the paramedics transport V.A. "to a more distant facility, where he had privileges," Dr. Johnson acknowledged the importance of continuity of medical care. However, she opined that respondent "should not place his desires [to continue caring for V.A.] over the needs of the patient." In her opinion, this was a simple departure from the standard of practice. She noted that respondent arranged for Dr. Cleek to see V.A. immediately.

63. Respondent did not offer any expert opinion testimony to contradict Dr. Johnson. Instead, he urges that Dr. Johnson's opinion testimony should be given little weight because she did not know all the facts and because she was not provided with policies and procedures governing EMTs who encounter a patient's physician when they respond to an emergency.

64. *Sierra-Sacramento Valley EMS (S-SV EMS) Policies:* S-SV EMS is the governing EMS agency covering the Butte County and the Chico area. It publishes policies and procedures followed by First Responders. The EMTs agreed they were bound by these policies.

65. *S-SV EMS Policy Policy 505:* This policy, which is a direct quote from California Code of Regulations, title 13, section 1105, subdivision (c), provides that "[i]n the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed and prepared to receive emergency cases, and administer emergency care appropriate to the needs of the patient." Under Decisive Factors, "Private Physician's Request," the policy states that when a physician makes a request for emergency transportation to a hospital other than the most accessible acute care hospital, the request should be honored unless, *inter alia*, "the paramedic provider determines that such transportation would unreasonably remove the unit from the area." In such cases, alternative arrangements should be made "appropriate to the medical needs of the patient." "If alternative transportation cannot be arranged without unacceptable delay, and the private physician is immediately accessible, the patient may be transported to a mutually agreed-upon alternate destination."

66. Both Mr. Kleinschmidt and Mr. Ruttan testified that they determined that removal of their unit from the area was not reasonable because there were few units available. For this reason, they could not honor the request to transport V.A. to OMC. Further, V.A.'s condition required her to go to the closest, most accessible facility.

67. *S-SV EMS Policy 839 Physician on Scene:* This policy provides:

It is the policy of the S-SV EMS Region that a Paramedic or Advanced EMT encountering a physician on the scene shall maintain responsibility for patient care unless the physician assumes responsibility for patient care and accompanies the patient to the hospital.

The Paramedic or Advanced EMT may assist the patient's physician provided the Paramedic or Advanced EMT operates within the approved S-SV scope of practice.

68. Policy 839 also provides a procedure for those circumstances where the physician on scene is the patient's physician, rather than a bystander. This procedure provides that the Paramedic or Advanced EMT is to: (1) require the physician's I.D. if he/she is unknown to them; (2) the patient's physician may administer medication from his/her drug inventory; (3) the Paramedic or Advanced EMT "may follow the patient's physician's orders if they do not conflict with the Paramedic or Advanced EMT scope of practice;" and (4) where "there is a conflict between the patient's physician's orders and the Paramedic or Advanced EMT scope of practice, explain that you can legally only treat within the S-SV Paramedic or Advanced EMT scope of practice. Contact medical control and ask patient's physician to discuss any problem issues with the base hospital."

69. Based on V.A.'s substantial blood loss and her vital signs once she was assessed, the EMTs determined V.A. needed to be transported to the closest and most appropriate facility. To do otherwise, would have deviated from their standard of care and placed V.A. at risk. In addition to its proximity, they noted that Enloe is a Level II trauma facility. Both of these witnesses further testified that respondent never stated that he intended to ride with V.A. in the back of the ambulance. Once V.A. elected to go to Enloe, there was no obligation to call the base hospital to resolve a conflict with a physician.

Discussion

70. Respondent's position that it was not necessary for the EMTs to obtain V.A.'s vital signs or to assess her because he had already done so before they arrived is not persuasive. Respondent testified that he had assessed V.A. before the EMTs arrived and knew she was stable. In his July 13, 2012 interview with Board investigator Shane Wright and medical consultant Kevin Mitchell, M.D., however, respondent stated that it was hard to tell if V.A. was stable or not because he did not have a blood pressure cuff. He also said he was sure she was unstable. Respondent indicated that he could feel V.A.'s pulse, estimate the amount of blood she had lost from looking at the used wound vac canisters, and he knew that she was dropping below a 100. He had V.A. sit up, and then walk a few steps. Once she collapsed while walking, respondent knew she needed to go to the hospital right away.

Other than to say he had a pulse ox reading, respondent never communicated his assessment to the EMTs. Moreover, he never told B.A. the results of his assessment; i.e., that V.A. was in urgent need of medical care. This contributed to B.A.'s agreement to transport to OMC and led to further discussions about other options to save money, ultimately causing delay in transporting V.A. to the hospital.

71. Respondent's testimony that he did not interfere with the EMTs was not persuasive. In his testimony and in his interview, respondent denied blocking the EMTs, struggling with the gurney, or prevent them from taking V.A.'s vital signs. He just asked them to hurry up. Respondent stated during his interview that taking V.A.'s vital signs was "academic;" and he may have said "we can take vitals signs till hell freezes over, but we know that she is going to the hospital." He wanted them to do this "there." Respondent conceded that he "probably didn't use all [his] best demeanor," but he believed the EMTs were too slow, trying to do things he thought were superfluous. He also conceded that he was "pretty possessive" about V.A.'s care. In his testimony at hearing, respondent stated that he might have raised his voice but it was done only out of a sense of urgency and not of anger.

72. The testimony of both Mr. Kleinschmidt and Mr. Ruttan about respondent's interference was very credible. Both witnesses consistently described respondent's refusal to allow them near to V.A. to obtain her vital signs, as well as his aggressive manner that included yelling and physically blocking them. The most neutral of all the witnesses was Mr. Ruttan, who testified that Mr. Kleinschmidt remained calm in his dealings with respondent. After being verbally assaulted by respondent, Mr. Kleinschmidt became visibly flushed. While Mr. Ruttan could tell that he was upset, Mr. Kleinschmidt never became verbally aggressive with respondent. Unlike the other witnesses on this issue, neither of the EMTs had any motive to fabricate.

73. It is undisputed that it was an unusual situation to have a patient's physician present at a home to which EMTs respond. Mr. Kleinschmidt has worked in emergency services in various capacities since 2003. He testified that he had never had an interaction with a physician on scene before. Mr. Ruttan had only encountered this situation twice in thousands of emergency calls. Respondent testified that he worked with many paramedics in the hospital, but never in this situation where both were at a house call.

74. Nevertheless, respondent's attempt to divert the attention from his conduct to whether the EMTs followed procedure is not persuasive. Neither S-SV EMS's Policies, nor the fact that Dr. Johnson was not provided them, significantly alter the weight or viability of Dr. Johnson's expert opinion regarding the appropriate standard of care. While there may be some unique situations where a doctor should not allow the EMTs to do their job, that situation was not present in this case. Respondent testified that he was not aware of these policies and procedures. Respondent's conduct resulted in delay in making the appropriate decision about where and how to transport V.A. This was an extreme departure from the standard of care.

75. Respondent's conduct of arranging for V.A.'s care by Dr. Cleek so she would be seen and treated quickly once at Enloe is a mitigating factor.

IV. Respondent's Alleged Impaired Ability to Practice Medicine Due to Mental or Physical Illness Affecting Competency: Request to Revoke License and/or Revoke Probation

76. Complainant alleges that respondent has a cognitive impairment that adversely affects his ability to practice medicine safely and that his license should be revoked to protect the public. Further, complainant alleges that respondent is in violation of probation because he did not pass the neuropsychological examination recommended by the PACE Program."

77. *Probation Condition 1 - Clinical Training Program:* The only probationary condition at issue in this case is Condition 1, which requires that respondent participate in and complete a two-day comprehensive assessment program and a 40-hour clinical education program at PACE or an equivalent program. Probation Condition 1 further provides that:

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding . . . Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

78. *Respondent's Participation in the PACE Program:* On September 8, 2009, PACE Director William A. Norcross, M.D., reported the results of respondent's Phase I and Phase II evaluations.

Phase I: Respondent attended Phase I of the PACE Program on March 16 and 17, 2009. He worked with PACE evaluator Sheila Pickwell, Ph.D., CFNP, and with Marek Dobke, M.D., Head of the Plastic Surgery Division. Respondent completed various self-report measures; he performed a mock patient history and physical; he participated in a physical examination by Dr. Pickwell; he completed the Microcog computer-based assessment of cognitive skills and the PRIMUM, a computerized test of clinical decision-making and patient-management skills in eight computer case simulations; and he

participated in a Transaction Stimulated Recall (TSR) based on the same case simulations. Working with Dr. Dobke, respondent underwent a one-hour oral clinical examination in Plastic Surgery and submitted nine chart reviews for assessment. He also completed examinations in ethics and communications, pharmacotherapeutics with inpatient care module, mechanisms of disease and surgery clinical science.

During Phase I, it was noted that respondent “performed below average on all standardized tests created by the [National Board of Medical Examiners]. However, he performed a good history and physical examination on the mock patient, and performed satisfactorily during the oral clinical examination with Dr. Dobke. His nine chart notes varied in quality. Six of his charts were rated as “Met Standards,” one was rated as “Sets Standards,” and two were rated as “Does Not Meet Standards.”

Cognitive Screening Test: Dr. Norcross’s report described the Microcog as “a computer-based assessment of cognitive skills” which “is a screening test used to help determine which PACE participants should be referred for full neuropsychological evaluation. This test is a screening instrument only; it is not a diagnostic tool. It does require proficiency with computers; a proctor is available to answer question about test instructions.” The PACE report stated in relevant part:

When [respondent’s Microcog] scores were not (sic) compared to age and education corrected norms he scored below average to low average in several categories, while scoring average in one category.¹⁵ He scored below average in information processing speed, reasoning/calculation, spatial processing, and reaction time. He scored low average on general cognitive functioning, general cognitive proficiency, attention/mental control, and memory. He scored average on information processing accuracy. Based upon his poor performance, we recommend that he undergo a complete neuropsychological evaluation to rule out any cognitive impairment.

Phase II: Respondent attended Phase II of the PACE Program on June 22 through 26, 2009. During this 40-hour program, respondent worked with Dr. Dobke and was “exposed to multiple operative room surgery cases, as well as outpatient clinical sessions, postoperative follow-up visits, and Divisional Grand Rounds. His knowledge and clinical competence were rated as good. His decision-making ability and competence in selected tested areas of plastic surgery was adequate.”

¹⁵ No one from PACE testified. Syntactically, the word “not” seems to be an error, suggesting that respondent’s scores were compared to age- and education-corrected norms. There is nothing in Dr. Norcross’s report to suggest that respondent’s scores were compared to non-normative age groups.

Dr. Norcross concluded:

Based upon his overall performance, Dr. Morgan has successfully completed the UCSD PACE Program. However, we recommend that he undergo a complete neuropsychological examination as a result of his poor performance on the Microcog Cognitive Screening Test. We suggest that Dr. Morgan have this performed by a seasoned clinical neuropsychologist with experience assessing physicians. We are able to provide this type of neuropsychological evaluation as well if Dr. Morgan is unable to find a suitable clinician in his area.

79. Following PACE's recommendation, the Board referred respondent to three examiners for evaluation. Each evaluator was asked to provide their professional opinion on three questions: (1) does respondent have a physical condition or illness affecting his competency; (2) is respondent's ability to practice medicine safely impaired by either mental illness or physical illness affecting competency; and (3) does respondent require medication/psychiatric treatment in order to practice medicine safely?

80. EXPERT EVALUATIONS AND OPINIONS: In support of its position, complainant called Dr. Roeder as its expert witness. Dr. Froming did not testify; however, the parties stipulated that Dr. Froming's declaration and report would be considered as her direct testimony. The report of Dr. Schafer was admitted as administrative hearsay and considered to the extent permitted by Government Code section 11513, subdivision (d).¹⁶ Respondent called Glenn Hammel, Ph.D., and Alan E. Brooker, Ph.D., as expert witnesses. Dr. Hammel prepared a report entitled Neuropsychological Evaluation, which included the results of his eight-hour clinical interview with respondent, his assessment of respondent's positive cognitive functioning as demonstrated in his PACE performance and in Dr. Schafer's evaluation, and his professional assessment and criticisms of the evaluations of Drs. Froming and Roeder. Dr. Hammel's evaluation did not include any independent neuropsychological testing.

81. Neurological Evaluation of John A. Schafer, M.D.: Dr. Schafer is a Board-certified psychiatrist and neurologist who conducted a neurological examination of respondent following his review of the PACE Program Report, the Stipulated Settlement and Second Amended Accusation. Dr. Schafer administered the Mini Mental Status Exam and the Boston Aphasia Panel to respondent, and conducted a clinical interview.

¹⁶ Government Code section 11513, subdivision (d), provides in pertinent part that "hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions..."

In his May 10, 2010 report to the Board, Dr. Schaefer's impressions were that: "[d]espite the report of performance below average or in low average range on a computerized testing battery, including tests of visual-spatial skills, Dr. Morgan does not demonstrate clinical evidence of dementia or of neurological disorders associated with dementia. These would include disorders such as Alzheimer's disease, fronto-temporal dementias, Parkinson's disease, Lewy body disease or other extrapyramidal disorders." Dr. Schaefer noted that peripheral neuropathy was also evident on the examination. Based on the available medical information, the cause was not apparent, but is consistent with aging. Dr. Schaefer deemed this to be an "incidental finding" with no relevance to causes of cognitive impairment or respondent's ability to practice medicine.

Dr. Schaefer concluded that there was no evidence of clinically significant cognitive impairment or of any neurological disorder which would render respondent unfit to practice medicine. In his opinion, the computerized cognitive test results "would appear to be mild and not of magnitude making him unsafe to practice."

82. *Dr. Froming's Neuropsychological Evaluation Report:* Dr. Froming is a Diplomate in Clinical Neuropsychology of the American Boards of Professional Psychology and of Clinical Neuropsychology. In addition to private practice (clinical neuropsychology and psychotherapy), Dr. Froming has worked with the Department of Psychiatry, Langley Porter Psychiatric Institute, University of California, San Francisco, as an assistant clinical professor in psychiatry, as a supervisor in the clinical psychology training program, and as a consulting psychologist. She is also an adjunct faculty at the Pacific Graduate School of Psychology.

83. In anticipation of her evaluation, Dr. Froming was provided and reviewed documents that included: Dr. Schaefer's report, the PACE Program Report, the Stipulated Settlement and 2005 Second Amended Accusation, various Probation Quarterly Reports, and a standardized adult neuropsychological history questionnaire completed by respondent. Dr. Froming then interviewed and evaluated respondent at his Chico office on July 30 and 31, 2010. Respondent was 74.9 years old at the time of this evaluation.

84. In her August 22, 2010 report to the Board, Dr. Froming characterized respondent as "extremely belligerent" to her both on the phone and at their initial meeting, expressing a belief that she was part of a "sham review" process. She observed that respondent's office staff was very solicitous of him and "clearly kept track of him," and she noted that respondent "can engender fondness in others." She added that respondent's "defensiveness, anger, and paranoia are a product of both the process he is undergoing, his cognitive dysfunction, and to some extent what may be some personality characteristics."

85. Following a clinical interview, Dr. Froming administered a series of tests to respondent that were designed to measure his capabilities in the areas of attention, memory functions, visual spatial and perceptual function, language function, motor skills, executive functions, psychological functioning, and malingering. Her assessment of respondent's performance is described below.

86. *Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV)*. Dr. Froming stressed the importance of viewing neuropsychological tests within the context of the examinee's level of achievement and intellectual capacity. Based on respondent's completion of medical school and "over 36 years" practice as a surgeon, Dr. Froming noted respondent's superior level of accomplishment. To assess respondent's intellectual abilities, Dr. Froming administered four out of the 11 WAIS-IV subtests: Similarities, Vocabulary, Symbol Search, and Coding. Dr. Froming used the Advanced Clinical Solutions – Premorbid Functioning, which is associated with the Wechsler Scales, to determine respondent's "pre-existing intellectual level." She determined that respondent's "predicted IQ estimation was 118 or above average." While respondent scored 116 on Word Reading, his Verbal Comprehension Index (comprised of the Similarities and Vocabulary subtests of the intellectual test) yielded a score of 102 or the 55th percentile. She noted that "[w]hile this is an average score it likely represents a decline relative to [respondent's] peak performance of his earlier, healthy life. This is particularly in light of some of his verbal memory Index scores that are somewhere between 120 and 130."

87. *Attention*: Dr. Froming administered the Mesulam Directed Attention Task (Mesulam), the Digit Vigilance, and the Delis Kaplan Executive Function System (DKEFS) to assess respondent's attention.

a. The Mesulam is designed to measure sustained attention in distracting conditions. The client is instructed to cross out target letters or figures that appear in a random array on a page as quickly as possible. "The average person takes approximately 60-80 seconds to perform the task without errors." Dr. Froming stated that respondent's performance "was noteworthy for not understanding the instructions," even after repeated explanation. Respondent's "difficulty with the directions prompted an angry condescending comment ("is there supposed to be a purpose to this test?"). Respondent performed significantly better, although not error-free, on letter arrays than on figure arrays.

b. On the Digit Vigilance (quickly cancelling all 6's in a digit array), respondent had a 7 scaled score on "time" and an 8 scaled score on "errors." Scaled scores of 6-7 are low average and scaled scores of 8 to 12 are average. She noted these were "age and education corrected scores."

c. Dr. Froming administered the DKEFS's Trail Making Tests and Color-Word Inference Test to respondent. The Trail Making Tests looks at sustained and divided attention, in the context of drawing a line between numbers and letters in sequence and then alternating between the two. Dr. Froming explained that these tasks mirror environments, such as an operating room, where the surgeon is listening to reports of other personnel, using motor actions, visually assessing the target field, asking for different instruments, and receiving and sending feedback. She reported that, on five different trails, respondent received scaled scores ranging from a high of 14 (above average) to a low of 9 (average) in letter sequencing. In the trail for number sequencing, respondent received a scaled score of 11 (average). Despite these average and above average scaled scores, Dr. Froming reported:

[respondent] was in the average to below average range on tasks requiring sequencing. However, he also demonstrated some pathognomonic (pathological) signs that include connecting the 'dots' with letters or numbers in the wrong order. These areas are not frequently found...His previous ability was in all likelihood superior given his previous skill level.

The Color-Word Inference Test examines the "attentional system" with a combined divided/selective attention task and a cognitive flexibility task, in the context of rapidly naming colors or reading words printed in different colors (e.g., the word red might be printed in blue), and saying the words only when bound by a rectangle. On the interference task, respondent received scaled scores of 13 (above average, word reading); 11 (average, color naming); 10 (average, color-word inhibition); and 8 (average, inhibition/switching). Dr. Froming indicated that respondent showed decreased cognitive flexibility on this latter, average-range score. Dr. Froming also provided Cumulative Frequency Ranks (CFR); for example, respondent's CFR for "word total errors" was 10 percent, showing that 90 percent of individuals scored better than he did.

88. *Memory Functions:* To assess respondent's memory functions, Dr. Froming administered the Wechsler Memory Scale –IV (WMS-IV), the Rey Osterrieth Complex Figure Immediate and Delayed Recall (Rey-O) tests, and the California Verbal Learning Test-2 (CVLT-2).

a. Regarding the WMS-IV, Dr. Froming noted that:

...because of his above average IQ estimation, I administered the Older Adults Battery with norms (65-90 years) as well as the standard WMS-IV battery (16-69). My rationale for doing this is that he is currently functioning at a high demand job that requires peak performance. It is simply not sufficient to assess how he is functioning as a 74 year old man but to see how he compares to individuals who are in the prime of their professional careers or even at the upper reaches of the younger sample.

On the Younger Adults WMS-IV, using norms for a "68 years, 10 months old person," respondent received the following results:

<u>Index</u>	<u>Score</u>	<u>Percentile</u>	<u>Classification</u>
Auditory Verbal Memory	120	91st	Superior
Visual Memory	89	23rd	Low Average
Delayed Memory	100	50th	Average

On the Older Adults WMS-IV, using norms for his actual age (74.9 years), respondent received the following results:

<u>Index</u>	<u>Score</u>	<u>Percentile</u>	<u>Classification</u>
<u>Auditory Verbal Memory</u>	130	98th	Very Superior
Logical Memory I Immediate			
Scaled Score (SS)	13	84th	High Average
Logical Memory II			
Delayed SS	12	75th	Average
Verbal Paired Associates I			
SS	18	99.6th	Very Superior
Verbal Paired Associates II			
Delayed SS	16	98th	Superior
<u>Visual Memory</u>	102	55th	Average
Visual Reproduction I			
SS	13	84th	High Average
Visual Reproduction II			
Delayed SS	8	25th	Average
Symbol Span SS	9	37th	Average
Delayed Memory	112	79th	High Average

Dr. Froming noted respondent's relative weakness in Visual Memory using both sets of norms, as well as his "relatively preserved Verbal Memory function that is more consistent with his premorbid functioning and level of achievement" (in the superior to very superior range). By contrast, under either norm set, respondent's Visual Memory Scores were in the low average to average range. Dr. Froming opined: "While normally one would look at performance in the average range as 'normal,' it is very likely not normal for Dr. Morgan whose livelihood of surgery is dependent on his visual memory for the details of his particular surgical procedures. While his immediate performance might be adequate his loss of information over even the minimal time delays are significant."

b. The Rey-O is a test that involves the use of both visual and motor modalities, which is designed to measure immediate recall (after a delay of three minutes) and delayed recall (after a delay of 20 to 30 minutes). Respondent was asked to copy a figure of a house with 18 different details and to recall the figure. Though there are no time constraints in copying the figure, Dr. Froming noted that respondent took more than 12 minutes to copy the figure which was "highly significantly slow even for his age." His recall after copying the figure was 16 out of 36 points or 73rd percentile. Dr. Froming added that respondent's ability to recall the figure was enhanced by his length of exposure to it.

c. CVLT-2 tests executive-organizational functioning by use of a 16-item "superspan list" that is further divided into four categories. The goal is to see how many words an individual can recall after five trials. A second list with shared categories is then

introduced and immediate and delayed recall of the first list is requested. Respondent recalled fewer items when the new list was introduced, showing some retroactive interference. He also had a greater number of repetitions. Respondent's performance trials were 7, 10, 12, 10, and 12 out of 16 total words. His total recall was 51 items for a score of 65T, which was one standard deviation above average.¹⁷ Dr. Froming noted that "overall [respondent's] above average performance in learning is marked by inefficiency in recall, interference, perseverations, and intrusions (off list items)."

89. *Visual Spatial and Perceptual Function:* Dr. Froming reported that "there is no evidence of visual perceptual or spatial disorder." Respondent's performance on the Rey-O figure copy "was unimpaired;" he was able to identify visually presented words on the DKEFS; he could recognize shapes on the Visual Reproduction on the WMS-IV, and "see details of the Sorting cards while not being able to identify the concept."

90. *Language Function:* Dr. Froming assessed respondent's language both informally as well as formally with the Boston Naming Test (BNT), the Mesulam Attention task, and the DKEFS Verbal Fluency measure. She indicated that respondent "did not appear to have any difficulties with initiation or fluency and could express himself with ease." Respondent had no difficulties on the BNT (56/60 correct, with four "classic semantic paraphrastic errors, identifying a word in the same category as the target). Respondent did ask for repetition of instruction or for clarification after task initiation more often than expected. On the Mesulam, respondent's "confusion was so marked that he completely missed the task." Dr. Froming did "not believe this was frank language impairment but a matter of attention, distractibility, and processing speed." Respondent's verbal fluency on the DKEFS was average for both letter fluency (SS=12) and category fluency (SS=10).

91. *Motor Skills:* Respondent is right-hand dominant. To assess respondent's motor skills, Dr. Froming evaluated his strength (dynamometer or grip strength: T score 48 right, 50 left); gross motor skills (finger tapping: T score 52 right, 47 left), and manual dexterity (grooved pegboard: T score 37 right, 41 left). "In addition, observations included the absence of consistent tremor but a mild tremulousness possibly due to tension, anger, or nervousness."

92. *Executive Functions:* Dr. Froming assessed respondent's executive functions using the DKEFS Card Sorting, Design Fluency, and Tower tests, the screening of Judgment Questions and the Smell Identification Test.

a. *DKEFS Design Fluency:* This test requires the examinee to connect five to 10 dots in an array using four straight lines and only four lines, without repetition in 60 seconds. There are five trials which involve connecting only filled dots, only empty dots, and alternate dots. Respondent scored in the low average to average range, with a total scaled score of 7 (low average) on design fluency and a total "set-loss errors, not following rules" of 6 (low average). Dr. Froming reported that respondent "performed in the low average range in his

¹⁷ The T score has a mean of 50 and a standard deviation of 10T.

ability to quickly perform visual motor rule bound productions. He also had difficulty following the rules. The visual motor performance on this task mirrors the impaired visual motor slowing found on the Grooved Pegboard task.”

b. DKEFS Card Sorting: Respondent was required to sort six cards into two groups of three cards each according to some attribute (for example, background pattern). Dr. Froming reported respondent had difficulty following the rules, required “multiple repetitions of the instructions,” and became “agitated” during this testing by expressing that the procedure seemed to have no point to it. She characterized respondent’s “performance on this task [as] one of the most impaired I have seen.” On the second portion of this test, where the examiner performed the sort and he was to identify it, respondent scored in the average and low average range. Dr. Froming indicated that respondent’s performance on this test “was highly unusual” with “other more pathological features” contained within the overall scores, including repeated sorts/descriptions and incorrect or idiosyncratic sorts/descriptions.”

c. DKEFS Tower Test: Respondent had a total achievement scaled score of 8, in the average range, on this measure of visual spatial planning and problem solving. Dr. Froming reported that he had “difficulty with all aspects of this task” and that he had a CPR of 18 for “total rule violations, indicating that 82 percent of the sample scored higher than he did.” She reported it was “likely” that respondent’s visuomotor spatial weaknesses impact his performance as well.”

d. Screening of Judgment Questions:¹⁸ Respondent scored 13/20 on this 10-question test, giving partial answers and requesting that questions be repeated. Examples of questions posed were “why shouldn’t you leave a child home alone” and “why shouldn’t you turn off an electrical appliance with wet hands.” Dr. Froming opined that “it appeared to me that these partial responses were more due to his grandiose personality style. He could not believe I would ask him such simple questions. In other words he thought the responses were so obvious as not to require a full explanation.”

e. Smell Identification Test: This test of identifying common odors is an early marker of many neuropsychiatric disorders (e.g. Alzheimer’s Disease). Respondent scored in the 74th percentile, showing no impairment.

93. *Psychological Functioning*: Dr. Froming administered the Personality Assessment Inventory (PAI) to assess respondent’s psychological function, using five validity scales to analyze his response style or biases. Respondent completed all items and his “scores were within acceptable limits for Inconsistent Responding, Negative Impression Management, and Positive Impression Management. His tendency is to deny personal failings.” Dr. Froming then noted that respondent’s “Infrequent Responses are so significant as to make the entire profile invalid.” Infrequent responses refer to “responses that few

¹⁸ It was unclear whether the screening of Judgment questions was part of the DKEFS. Dr. Froming did not list this separately in her report under Tests Administered.

people endorse. The suggestion is of someone who had problems attending to or interpreting item content in responding..." Dr. Froming noted that, on a "couple of questions," respondent had difficulty comprehending items "in which there was a negation of the endorsed item. He would ask which meaning the item meant; when he received clarification he indicated his confusion . . . Given Dr. Morgan's impairments in attention, that is also a likely contributor." Though Dr. Froming found the PAI to be uninterpretable, respondent's score on a single subtest, the Somatic-Health Concerns, was noted to be significantly elevated.

Dr. Froming reported that during the clinical interview, respondent denied any depression or psychiatric symptoms. She observed him to express "paranoid ideation (beyond the realistic view that he is being examined)." In her opinion, respondent believes that he lost hospital privileges (at Enloe) due to a conspiracy on the part of the head of the hospital which may extend to current Board issues. He expressed distrust for the integrity of the review process and a belief that she was trying to trick him.

Dr. Froming wrote:

[respondent] also reports not adhering to common practices such as wheeling patients out to the curb because 'I ask them to walk out because if they can't walk, they shouldn't go home yet.' While there is some logic to this, he also ignores clear safety/liability issues. This is a common style for Dr. Morgan to believe that his judgment, tried and true, is better than what might be common practice. Dr. Morgan had rapidly shifting moods throughout the testing days.

Dr. Froming administered the Structured Inventory of Malingered Symptoms (SIMS), the Test of Memory Malingered (TOMM), and the verbal portion of the Validity Indicator Profile (VIP). Respondent's subtest scores on the SIMS did not indicate malingering and he scored perfectly on the TOMM's forced choice test of simple visual memory. The VIP is designed to identify valid and invalid responding. Respondent produced an inconsistent and invalid protocol on this test, which Dr. Froming indicated was not an accurate representation of his strong verbal ability. She opined that respondent may have been too tired or insufficiently invested in the task.

94. *Dr. Froming's Opinion:* Based upon her evaluation, Dr. Froming reported her "expert opinion that Dr. Morgan is suffering from neuropsychological impairments that impair his ability to practice medicine. Not only are his cognitive skills impaired in areas that are important to his practice of medicine but his judgment and resulting psychiatric state also make his continued practice dangerous." She reasoned that, in light of respondent's training and experience, "his premorbid or pre-illness estimated IQ is at least 118 ...His verbal scores on the memory scales indicated even higher ability when the scores are on an equivalent scale (his verbal memory quotient is between 120-130). However, on the Wechsler Adult Intelligence Scale-IV Vocabulary and Similarities subtest that comprise the

Verbal Comprehension Index, Dr. Morgan achieves a score of 102. This is approximately 1 standard deviation below his premorbid estimations and 1-2 standard deviations below his verbal memory quotient. It is likely a decline.”

Dr. Froming noted that respondent “demonstrated a statistically and clinically significant split between verbal and visual memory tasks (verbal memory quotients 120-130 depending on younger vs. older norms and visual memory quotients are 89-100 depending on the norms used.) A thirty point split is highly unusual and indicates an impairment ... This is especially true for someone who relies on visual memory, knowledge of landmarks, and visual recall of what might have just transpired.” Dr. Froming noted that assessments of respondent’s visuomotor abilities indicated that his “motoric performance in (sic) slowed and he has fine motor, dexterity problems.” She also noted that the PACE MicroCog “also found a declines (sic) on the visuospatial/ memory subtest...” Dr. Froming expressed concern about respondent’s executive functions where his “greatest difficulties were on abstract reasoning, complex problem solving, cognitive flexibility and inhibiting errors.” While “many of his performances fall in the average range,” she believed that these types of tasks were easier for respondent in the past.

In addition to the cognitive problems Dr. Morgan is having his reaction to these problems is of concern. From interview it is my belief that Dr. Morgan frequently has his ‘rules’ or ideas about things. He has a grandiose, condescending style at times but can immediately become very charming and ingratiating. He shows mood lability and suspect judgment. He seems to be externalizing blame for his difficulties.

The combination of paranoia, grandiosity, mood lability, and cognitive decline, make his judgment and skills in question. Obviously this is [sic] extremely stressful situation for Dr. Morgan but regardless of that difficulty he is unable to consider patient safety. Consequently my recommendations are that he is too impaired to practice.

95. Based on her evaluation, Dr. Froming opined that respondent “is suffering from neuropsychological deficits” that “impact visual memory, abstract reasoning, problem solving, and strategizing. He is slower in his processing speed and shows some right-handed fine motor decline.”

She also opined that respondent’s “neuropsychological impairments combined with his psychiatric response to them impairs his ability to safely practice medicine. His psychiatric state at present lends itself to mixed personality features of paranoia and narcissism. In some ways these are likely an exacerbation of a pre-existing personality style but worsened due to his cognitive decline.”

Finally, Dr. Froming opined that “it is not likely that treatment will impact these changes.” She recommended that a neurologist should “rule out treatable causes of cognitive decline” but expressed her belief that there are no treatable causes of neuropsychological decline at work.” Regardless of the Board’s decision on licensure, Dr. Froming recommended that repeat testing be conducted “in approximately one year.”

96. Dr. Hammel’s Opinions Regarding the Validity of Dr. Fromer’s Evaluation: Dr. Hammel is a licensed clinical psychologist with sub-specializations in clinical neuropsychology and clinical geropsychology (the study of cognition, personality, and social functioning at the later years of a person’s lifespan). He has maintained a private practice since 1995 and has conducted approximately 500 neuropsychological evaluations. Dr. Hammel was hired by respondent to provide his opinions of respondent’s neuropsychological functioning. He prepared a May 25, 2011 Declaration, in response to the Board’s ISO Petition, and an October 1, 2013, Declaration and Neuropsychological Evaluation Report setting forth his opinion that respondent is cognitively intact and does not have a diagnosable, disabling cognitive disorder.

As reflected in his Declaration and testimony, Dr. Hammel offered opinions criticizing Dr. Froming’s neuropsychological evaluation of respondent on numerous grounds. The overriding theme of these criticisms was that Dr. Froming exhibited clinician bias in her evaluation and used inappropriate norms, which invalidated her opinions about respondent’s ability to safely practice medicine. Dr. Hammel expressed concern that Dr. Froming had apparently discounted respondent’s successful participation at PACE, where he was clinically observed engaging in real world medical tasks for approximately 56 hours by several medical examiners. Dr. Hammel characterized PACE’s assessment methodology as one which appears to have a strong “ecological validity,” based on the degree of congruence between the behaviors and skills observed during that assessment and those which actually occur in natural, clinical settings.

Dr. Hammel strongly disagreed with Dr. Froming’s ultimate conclusion about respondent’s cognitive ability and ability to safely practice medicine. He testified that Dr. Froming’s raw test data, considered alone using appropriate norms, supports a conclusion that respondent is both cognitively and psychiatrically intact. He also opined that “cognitive decline” was not a diagnosis recognized by the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR)*, and that Dr. Froming dismissed Dr. Schaffer’s findings and inappropriately concluded that there was no treatment available for respondent. Dr. Hammel’s specific opinions are as follows:

97. Clinician Bias: Dr. Froming had a pattern of making disparaging, editorializing statements about respondent in the clinical interview portion of her report, rather than in the conclusion section. This is contrary to the usual practice in a neurological assessment report and it is one “that infers clinician bias.” For example, she described respondent as condescending, argumentative, angry and extremely belligerent. She characterized respondent’s judgment and insight as fair to poor, then indicated that the “[e]vidence of this is his attitude toward this examiner.” Based on Dr. Froming’s report and

Dr. Hammel's interview with respondent, there was "interpersonal acrimony" between respondent and Dr. Froming, which was not seen by any of the individuals who evaluated respondent (PACE staff, Dr. Schaffer, Dr. Roeder, or himself). Bias was also demonstrated in Dr. Froming's failure to address the positive cognitive findings of respondent's PACE performance, Dr. Schaffer's report, and respondent's negative finding for cognitive impairment on the Smell Identification test.

98. *Lack of Objective Testing to Support Opinions:* As part of his evaluation, Dr. Hammel attempted to tie Dr. Froming's opinions to specific objective findings. He found that she stated clinical opinions in her report which were not grounded in any objective test findings. For example, Dr. Froming discounted respondent's statement that he only drinks one glass a wine on Friday night if he is not flying the next day.¹⁹ She opined that this was "an underestimate of his drinking" and indicated that some of the deficits he exhibited "are consistent with serious alcohol consumption as one possible etiology." Dr. Froming failed to administer any alcohol abuse screening or other test to support her opinion on excess alcohol use. Her challenge to respondent's veracity was contradicted by the objective findings on validity profiles she administered, which did not indicate any lying, underestimating or amplification by respondent.

Dr. Froming also made a sweeping conclusion about respondent's ability to address patient safety issues by "not adhering to common practices such as wheeling patients out to the curb" and walking them to their car instead. In Dr. Hammel's opinion, it is appropriate for a neuropsychologist to disagree with respondent's approach; however, it is inappropriate to conclude that his practice of walking patients to their cars after surgery is evidence of "any kind of cognitive deficit or poor clinical judgment based in some kind of cerebral problem."

In addition, neither Dr. Froming's testing, nor her test data, support a finding that respondent has permanent right-handed fine motor decline. Instead, her finding was based on respondent's transient states of tension, anger, or nervousness. These impermanent conditions do not demonstrate an underlying organic fine motor pathology, which would need to be diagnosed by a neurologist.

99. *Use of Negative Psychological Terms/Impressions without Objective Basis:* In Dr. Hammel's opinion, Dr. Froming allowed her personal acrimony with respondent to blur her clinical judgment. She then pathologized respondent's "challenging but understandable resentment at having to endure a third evaluation of his capacity as a physician." Dr. Froming used "well-defined terms of [psychological] art" to portray respondent negatively, but she failed to support these impressions with any valid personality or psychological test findings. For example, Dr. Froming described respondent as suffering from 'paranoia' and she concluded that the "combination of paranoia, grandiosity, mood lability, and cognitive decline, make his judgment and skills in question." Dr. Froming then concluded that respondent's "neuropsychological impairments combined with his psychiatric response to them impairs his ability to safely practice medicine." As part of this conclusion, Dr. Froming

¹⁹ Respondent is a licensed pilot who passed his pilot's physical examination in 2012.

further opined that respondent's "psychiatric state at present lends itself to mixed personality features of paranoia and narcissism."

Dr. Hammel testified that it is inappropriate for a neuropsychologist to use these terms of art in an evaluation designed to support a recommendation that a physician is unable to safely practice medicine without objective testing to support their use. Such testing was completely lacking. Dr. Froming administered the Personality Assessment Inventory, but she reported that the entire profile was invalid. Although Dr. Froming did not "diagnose" respondent with paranoia, grandiosity or a condition manifested by mood lability, her use of these terms was "inherently diagnostic." She then relied on these "findings" as factors to question respondent's medical judgment and skills.

100. *Use of Inappropriate Normative Data:* In Dr. Hammel's opinion, Dr. Froming scored critical neuropsychological tests using normative data that was clinically inappropriate and this possibly played a role in leading her to form invalid opinions. Specifically, in assessing respondent's memory with the WMS-R, Dr. Froming articulated a need to compare respondent "to individuals who are in the prime of their professional careers or even at the upper reaches of the younger sample." Dr. Froming provided no scientific research on which to base this scoring practice. In Dr. Hammel's opinion, Dr. Froming showed an "ageist bias" against respondent by equating "peak performance" as congruent with relative youth, while at the same time discounting the value of respondent's many years of experience as an effective surgeon. In his opinion, the use of inappropriate normative data invalidates the test results.

101. *Erroneous "Pre-Morbid IQ" Extrapolation:* Dr. Froming only administered four of the WAIS-IV's 11 subtests and from them, extrapolated what she believed was respondent's IQ before he suffered cognitive impairment. Based on this extrapolation, she determined respondent had a "pre-morbid IQ" of 118. In Dr. Hammel's opinion, this analysis guided Dr. Froming's "entire notion that there is, in fact, a diminishment here." A year later, after being administered the full WAIS-III by Dr. Roeder, respondent's full-scale IQ was 118. (See Factual Finding 108.) Respondent's actual IQ at the time of Dr. Froming's assessment was in the above-average to superior range.

102. *Failure to Consider Non-Pathological Causes for Relative Weaknesses:* Dr. Froming's inappropriately concluded that the "scatter" in respondent's tests was necessarily indicative of cognitive impairment. Respondent performed in the high to superior range in some test areas; in others, he performed in the low average to average range. His low-average scores were derived from the use of improper norms.

In Dr. Hammel's opinion, there are several possible, non-pathological explanations for respondent's scattered scores. First, the scatter may simply reflect "normative variation found within an individual who possesses a strong intellectual capacity" (i.e., relative strengths and weaknesses). Second, the scatter "may be the normative reflection of non-pathological age related cognitive declines." Such normative aging processes are not synonymous with pathological aging, such as a dementia. While such declines may be

discernable within a neuropsychological setting, they do not necessarily have a significant impact “in the real-world setting such as a medical practice where an individual uses a host of conscious and unconscious cognitive adaptations, long-term experience, acquired skill sets and accrued wisdom to meet its demands.” By focusing only on respondent’s “relatively weaker test performances, Dr. Froming crafted opinions that have little congruence with Dr. Morgan’s actual real-world functioning.”

103. Dr. Hammel’s opinions raise substantial concerns about the weight to be given to the ultimate conclusions set forth in Dr. Froming’s neuropsychological evaluation report. Dr. Froming did not testify and no other expert opinion testimony was offered or elicited to rebut these concerns. Further, Dr. Hammel’s opinions found some support in the testimony of Dr. Roeder. While Dr. Roeder declined to render opinions specifically on Dr. Froming’s report, he testified to the following relevant points. First, during his two-hour clinical interview of respondent, Dr. Roeder made “no negative findings.” Respondent’s behavior and affect were appropriate; he was professional and cooperative, and he exhibited no anger or belligerence. Second, Dr. Roeder saw no indication that respondent was a chronic abuser of alcohol. Third, Dr. Roeder agreed that a neuropsychologist would not be able to render an opinion about respondent’s personality strengths or weaknesses without doing personality assessment testing. He did not diagnose respondent as paranoid, find him to be grandiose, or to exhibit mood lability or narcissism. Fourth, Dr. Roeder testified that the appropriate way to assess for impaired brain functioning is to consider examinees in relation to the normative functioning for their age group.

104. In the absence of any expert testimony to the contrary, Dr. Hammel’s opinions set forth above are persuasive. Extrapolating from a small subset of the WAIS-IV, Dr. Froming erroneously assumed that respondent’s I.Q. had declined from 118, in the above-average range, to 102, at the 55th percentile. Although Dr. Froming used both younger and age-appropriate norms to test respondent’s memory abilities on the WMS-IV, she continually referenced his low average results in her analysis. Using age-appropriate norms, respondent’s scores were in the average to very superior range. While respondent’s test results demonstrate areas of weakness, Dr. Froming’s ultimate conclusions about his ability to safely practice medicine are inextricably intertwined with her subjective opinions about his psychiatric conditions (e.g., “his judgment and resulting psychiatric state also make his continued practice dangerous.”) These factors diminish the persuasiveness and weight to be given to the findings and conclusions in Dr. Froming’s report.

105. Dr. Roeder’s Neuropsychological Evaluation Report: Dr. Roeder has maintained a private practice in Auburn since 1984, with a focus on forensic psychology and neuropsychology. Dr. Roeder is a member of various local, state and national professional organizations, including the American Psychological Association (APA), the National Academy of Neuropsychology and he is a member of specialty divisions in forensic psychology and neuropsychology. Dr. Roeder is on the Placer County Superior Court Panel in the areas of juvenile, criminal and family law. Since 1992, Dr. Roeder has served as an expert evaluator for the Board, reviewing standard of care complaints against psychologists,

and conducting psychological and neuropsychological evaluations of licensees for various professional boards under Department of Consumer Affairs.

106. On April 7, 2011, at the Board's request, Dr. Roeder conducted a neuropsychological evaluation of the then-76-year-old respondent. The Board's March 10, 2011, referral letter advised Dr. Roeder that respondent "did not perform well" on the Microcog Cognitive Screening Test and that PACE recommended he undergo a neuropsychological exam." Dr. Roeder was provided limited historical data (e.g., the prior decision and underlying accusation). He later requested additional background information from the Board, but this request was denied. Before testifying in this hearing, Dr. Roeder had never reviewed the PACE report.

107. For this evaluation, Dr. Roeder had respondent complete a "problem checklist" and he personally conducted a two-hour clinical interview of respondent. Dr. Roeder then caused the following tests to be administered to respondent: the Wechsler Adult Intelligence Scale – III (WAIS-III), the Wechsler Memory Scale – Revised (WMS-R), and the Luria-Nebraska Neuropsychological Battery – Form 2 (LNNB-II).

108. *WAIS-III Results:* On the WAIS-III, respondent received a verbal intelligence quotient (IQ) scale of 121, at the 92nd percentile; a performance-IQ score of 111, at the 77th percentile; and a full-scale IQ of 118, at the 88th percentile. The scaled score of "10" is average for the WAIS-III. On its 11 subtests, respondent scored at or above 10 in all areas except "block design," for which his scaled score was "09". These subtest and respondent's scaled scores were as follows: Information, SS-15; Digit Span, SS-12; Vocabulary, SS-13; Arithmetic, SS-12; Comprehension, SS-15; Similarities, SS=13; Picture Completion, SS-12; Block Design, SS-09; Matrix Reasoning, SS-16; and Digit Symbol-Coding, SS-12.

109. *WMS-R Results:* On the WMS-R, respondent's memory scores did not reflect any significant impairment. They were as follows:

	Verbal Memory	Visual Memory	General Memory	Attention/ Concentration	Delayed Recall
Indexes	109	122	116	114	124

110. *LNNB-II Results:* Dr. Roeder testified that neuropsychological testing is focused on determining whether a person can do tasks that the brain should be able to get them to do (brain-behavior relationships). Subjects are asked to perform a large number of easy tasks. Tests are designed to assess whether the examinee is experiencing any difficulties in their brain functioning by breaking down the smallest aspect of behavior.

To assess respondent, Dr. Roeder used the LNNB-II, which is a neuropsychological test battery derived from the work of the Russian neuropsychologist Alexander Luria. This test determines a "critical level" at or above which brain impairment is indicated, based on

the examinee's age and presumed intelligence. Respondent's critical level was 54. On the LNNB-II's 12 clinical scales (CS) and summary scales (SS), respondent's T scores were determined to be elevated above the critical level in four areas: arithmetic (CS 60); rhythm (CS 56); intermediate memory (CS 56); and impairment (SS 62). The LNNB-II's Localization Scales indicated that respondent scored 54 at L8, which is described as "Right Temporal." On the Factor Scales for this instrument, respondent received four elevated scores: in kinesthesia-based movement (CS 54); rhythm and pitch perception (CS 58); relational concepts (CS 54); and arithmetic calculations (CS 59).

111. Dr. Roeder described respondent's results as follows:

The LNNB-II results reflect impaired brain functioning on Dr. Morgan's part. As can be seen on page 1 of the Appendix, four of the clinical and summary scales, Rhythm, Arithmetic, Intermediate Memory and Impairment, are elevated beyond the critical level, an abnormal finding. The overall profile elevation, reflecting the number of errors Dr. Morgan made on these numerous tasks, is also reflective of impaired brain functioning and is further suggestive of brain dysfunction. While the Localization scales reflect more difficulty in the right cerebral hemisphere, consistent with Dr. Morgan's findings on the Wechsler testing, there is not a clear localization of his difficulties, reflecting more generalized impairment. Finally, the Factor scores reflect some significant areas of impairment, with four of these scores above the critical level, as specific difficulties in the areas of rhythm and pitch perception, concept recognition, arithmetic calculations and kinesthesia-based movement. Despite these specific findings, the Factor scores again reflect primarily generalized impairment rather than specific areas of loss or impairment.

Dr. Roeder emphasized that respondent's "significant, identifiable" impairments "are not severe, but fall more in the range of mild to moderate severity." Intermediate Memory was "much more impaired than short term memory." Respondent also had difficulty performing arithmetic calculations. These difficulties did not appear to be related to reading problems, test anxiety and/or attention and concentration problems, but were more reflective of "a moderate and generalized impairment" in his neuropsychological functioning. He was also noted to display hand tremors when completing some fine motor tasks."

112. In conclusion, Dr. Roeder rendered his opinion that these neuropsychological results "clearly indicate" respondent is "experiencing impaired brain functioning, confirming the concerns raised by the PACE program." Dr. Roeder noted respondent's "excellent verbal abilities. . . [at] the top eight percent of the population, corrected for his age." Respondent had "more difficulty with non-dominant hemisphere tasks such as perceptual organization, memory and processing speed, the neuropsychological testing indicating these decrements

occurred because of generalized impairment in his neuropsychological functioning of mild to moderate severity.” Respondent’s neuropsychological difficulties were reflective of “moderate and generalized impairment in his brain functioning, “rather than reading problems, testing anxiety and/or attention and concentration difficulties. “Specifically, the testing identified difficulties in the areas of rhythm and pitch perception, concept recognition, arithmetic calculations and kinesthesia based movement reflective of an individual with impaired brain functioning.”

113. Based on these neuropsychological test results, Dr. Roeder determined that the appropriate diagnosis for respondent under the *DSM-IV-TR*, was “Cognitive Disorder NOS.” This diagnosis (ICD code 294.9) is used: “...for disorders that are characterized by cognitive dysfunction presumed to be due to the direct psychological effect of a general medical condition that do not meet criteria for any of the specific deliriums, dementias, or amnesic disorders listed...and that are not better classified as Delirium Not Otherwise Specified, Dementia Not Otherwise Specified, or Amnesic Disorder Not Otherwise Specified. . . Examples include: 1. . . impairment in cognitive functioning as evidenced by neuropsychological testing or quantified clinical assessment, accompanied by objective evidence of a systemic general medical condition or central nervous system dysfunction...”²⁰

114. Dr. Roeder concluded that respondent has “a neuropsychological condition which affects his competency, his ability to practice medicine safely is impaired by his neuropsychological difficulties, and an individual with this level of neuropsychological impairment would not be competent to function as a practicing surgeon.” He recommended that respondent consult with his physician or “participate in a referral to a neurologist to rule out the possibility there is any acute or chronic medical condition which is contributing to his thinking difficulties.” He noted that “Dr. Morgan enjoys many well preserved areas of cognitive functioning...At the same time, the superior cognitive requirements for performing hand and facial surgery would lead to significant concerns regarding his ability to safely function in this capacity.” Even with such a referral, which “might result in an improvement in his neuropsychological functioning,” Dr. Roeder concluded that “the test results are reflective of a chronic and static level of functioning which is unlikely to change or improve so that he would be able to practice medicine safely.”

²⁰ The *DSM-IV-TR* was in effect at the time of Dr. Roeder’s evaluation. It assigns International Classification of Diseases (ICD) codes to various diagnoses. When he referenced the diagnosis Cognitive Disorder NOS, Dr. Roeder erroneously used ICD 294.0, which is assigned to “Amnesic Disorder due to General Medical Condition.” Dr. Roeder testified that this was an error and that he made no findings that respondent suffered an amnesic disorder as described by this ICD code.

115. *Dr. Roeder's Testimony:* Based on respondent's results on the WAIS-III and WMS-R, Dr. Roeder found no evidence that respondent had neuropsychological impairment. Respondent did well on all of the memory tasks, showing that his memory is "fine." Respondent's lowest score of 9 on the WAIS-III subtests was in block design. While this score is "average," it shows a relative weakness for respondent in light of his well-above-average intelligence. He noted that respondent received the highest score of 16 on the matrix reasoning task, which is a visual task like block design. Respondent has very good visual abilities. The difference is that block design requires both vision and motor functioning.

Intelligence tests are not designed to identify neuropsychological deficits. Some of the WAIS scales are sensitive to generalized impairment, for example, the digit symbol coding test. Dr. Roeder noted that this task requires "very complex brain functioning," and that many individuals with significant cognitive impairment will have difficulty with this task. Respondent did well on this task, demonstrating "very rapid information processing speed" (e.g., digit symbol-coding, SS=12). Dr. Roeder did find a consistency in the WAIS and the LNNB results in that both showed the difference between respondent's verbal and performance intelligence. While respondent's non-verbal intelligence is "still above average" at the 77th percentile, it is below what his verbal abilities are (92nd percentile). Similarly, on the LNNB localization scores, respondent did better on left than on right hemisphere tasks.

Dr. Roeder testified that respondent's LNNB test results indicate he is experiencing some neuropsychological impairment. Ideally, a surgeon should have no elevated LNNB scores. Dr. Roeder was particularly concerned about respondent's elevated score on the factor scale in "kinesthesia based movement," i.e., movement that is controlled or modified by feedback that the brain is getting from the body. While blindfolded, respondent was asked touch his thumb to either his second or fourth finger, but was not able to do so.²¹ This would be an important aspect of someone's ability to engage in the practice of, especially, a facial or hand surgery.

Dr. Roeder agreed that a relative weakness does not necessarily mean that respondent would be cognitively impaired. On the Wechsler, for example, respondent's relative weakness is still above average (e.g., performance IQ at 77th Percentile). Respondent's LNNB clinical scale and summary scores reflect impairment. Dr. Roeder cautioned against extrapolating these scores too far to say it indicates brain damage or disease; nonetheless, they show respondent has a problem with these tasks and cannot do them as well as would be expected, both for his age group and for any age. Dr. Roeder explained that respondent's range of scores on the LNNB "was actually within normal limits," but that the summary "impairment" score (SS=62), was his "highest score of all. So what we have is, it's almost like the death by a thousand cuts kind of thing." There are small impairments, no large areas of impairment, but at a level that is an abnormal finding.

²¹ Respondent testified that he did not recall being asked to perform any tasks while blindfolded.

Dr. Roeder clarified his opinion about the “superior” kind of cognitive requirements necessary for performing hand and facial surgery by explaining that he was asked to perform the assessment and to identify “any” impairment. He saw impairment in respondent’s results. He testified that this was a personal opinion, based on the superior ability level he would want for a surgeon operating on a family member. He also testified that the reference to “superior” cognitive requirements for a surgeon was not based on scientific research but meant that these tasks are “superior to just the activities of daily living.”

116. Dr. Roeder found several of Dr. Hammel’s criticisms of his report to be reasonable. In particular, he believed it a valid concern that he was not provided the full PACE report, and could therefore not compare respondent’s test scores and their theoretical implications against his actual successful clinical performance at PACE. When he asked the Board to provide additional information, he wanted a complete clinical picture of respondent to help in the evaluation. After having an opportunity to review these reports, data and results, however, Dr. Roeder testified that his opinion about respondent’s neurological impairment, diagnosis, and ability to safely practice medicine was unchanged. His results were consistent with the PACE results, in that both assessments showed some areas of difficulty, and that respondent had many more favorable overall results on his neuropsychological tests. He also clarified that he believed the Board acted appropriately to withhold these reports to keep him free from potential bias.

117. Dr. Roeder agreed with Dr. Hammel that his opinion that respondent is impaired and not able to safely practice medicine is solely based on assumptions extrapolated from his own test results. Specifically, Dr. Roeder “completely agreed” that “what is important is not whether he can find the cup with his eyes closed or knows whether the mother’s sister is the same as the sister’s mother, but how he actually performs as a surgeon.” If there is no impairment in the real world, test scores are academic.

118. Dr. Roeder also agreed that it is important to know the qualifications of the individual who administers the neuropsychological tests, and that his report did not disclose that he used a psychometrician to administer respondent’s neuropsychological testing. Dr. Roeder testified that such practice was part of his training and that it was not unethical to do so.²²

119. Dr. Roeder selected the LNNB battery for respondent’s evaluation because it is a wide-ranging approach that consists of 279 items in 12 different scales that covers all appropriate areas. Dr. Roeder agreed that the LNNB should only be used by experienced neuropsychologists, but explained that he has the requisite level of experience. Dr. Roeder

²² Dr. Roeder’s former employee Kathy Lawrence administered the tests to respondent. She was trained by Dr. Roeder and had over 15 years of experience doing so. Ms. Lawrence has a Bachelor’s degree in psychology, was not pursuing licensing hours or an advanced degree in psychology, and was not a licensed psychological assistant when she administered the tests to respondent. (See footnote 23.)

began administering the LNNB-I in the 1980s. Approximately 10 percent Dr. Roeder's clinical practice involves performing neuropsychological evaluations. He has performed psychological assessments on physicians. Dr. Roeder did not remember any specific cases where he performed a neuropsychological assessment on a physician (including plastic surgeons), but believed he has done so.

120. Dr. Roeder discussed his understanding of the controversy over the LNNB. The primary controversy has to do with the battery testing approach, seen in the LNNB, versus the hypothesis testing approach, where the neuropsychologist selects the initial and follow-up test instruments depending on the individual's response. The neuropsychologist must personally administer the tests instruments in the hypothesis testing approach, and use of a psychometrician would not be appropriate in this instance. He believed the hypothesis testing approach is superior where the diagnostic question is about a specific task, rather than general impairment. Dr. Roeder was trained in the LNNB and prefers the battery approach.

121. *Expert Opinions Regarding the Validity of Dr. Roeder's Evaluation:* Respondent called Dr. Hammel and clinical neuropsychologist Dr. Brooker to provide expert opinion testimony about Dr. Roeder's evaluation. As reflected in his Declaration and testimony, Dr. Hammel offered numerous opinions criticizing the validity of Dr. Roeder's neuropsychological evaluation. As indicated above, Dr. Roeder thoughtfully considered and responded to many of these criticisms. Respondent's greatest concern focused on whether the LNNB-II is regarded as a valid and reliable neuropsychological test. Both Dr. Hammel and Dr. Brooker offered testimony on this issue, which was best articulated by Dr. Brooker.

122. *Testimony of Alan E. Brooker, Ph.D.:* Dr. Brooker is a licensed clinical psychologist with a sub-speciality in cognitive rehabilitation. He is certified as a Diplomate in Clinical Neuropsychologist by both the American Boards of Professional Psychology and of Clinical Neuropsychology. Dr. Brooker testified that there are only 70 board-certified Diplomates in California, and that this designation establishes expertise in this field. Dr. Brooker is also board-certified as a forensic examiner. He is an independent medical examiner for the State of California, and has worked as a consultant on various cases with the California Board of Psychology. Dr. Brooker had an extensive military career, during which he worked as the United States Air Force's chief neuropsychologist for six years, and he received presidential honors for his work with the repatriation of American hostages from Iran.

Dr. Brooker knows Dr. Roeder through professional workshops. Dr. Roeder has referred patients to him, primarily for neuropsychological assessment on very complex cases.

123. Dr. Brooker is familiar with the LNNB-II used by Dr. Roeder. He was trained in the use of this instrument and used it from 1985 until 1986. Dr. Brooker testified that he stopped using this test battery because it has poor validity and poor diagnostic reliability for measuring what it was intended to measure. When a test lacks good validity and reliability, its use may result in false negative or false positive results, rendering a result that is totally meaningless.

Dr. Brooker testified that the LNNB is not a widely accepted test in the field of neuropsychology and is, in fact, viewed with disfavor. Dr. Muriel Lezak is the lead author of *"Neuropsychological Assessment (Fifth Edition 2012)"*, the most famous neuropsychological assessment book in use in the United States, in Europe and many other countries. In addition to his personal observations and experience, Dr. Brooker found scientific support for his opinion about the LNNB in Chapter 17, Neuropsychological Assessment Batteries, of Dr. Lezak's text.

As reflected in this chapter, the LNNB battery was derived from Luria's methods and ultimately converted into a test battery authored by C.J. Golden, Purish, and Hammeke. Dr. Lezak noted that "this battery has significant problems which have likely contributed to its virtual absence in peer-reviewed journal articles reporting recent independent studies." In addition, "many neuropsychologists have concluded that this battery is diagnostically unreliable;" readers are "advised against indiscriminate use of this battery," which "is only suitable for use by examiners with a good grounding in neuropsychology and its related disciplines." Dr. Lezak concluded this discussion with the following statement: "That the LNNB has left few traces in the current literature would seem to attest to well-grounded examiners' evaluation of this battery."

Dr. Brooker testified that the research has shown the LNNB not to be very efficacious in distinguishing between normal and abnormal brain behavior relationships, that the battery was not validated on patients without severe brain injury, that it does not discriminate frontal lobe-executive dysfunction very well, that it fails to capture certain aspects of memory (procedural), and that an external validation study was never done. As a consequence, the battery may not measure what it is intended to measure. Dr. Brooker testified that LNNB's primary author, Dr. Golden, no longer uses this battery. He has never seen any positive reviews of the LNNB.

124. In Dr. Brooker's opinion, if the LNNB battery is used by an experienced neuropsychologist, a battery of other tests should also be administered to either corroborate or show inconsistencies with its findings. For example, if the LNNB suggests a memory problem, "you better corroborate that with other memory tests, if you are an experienced neuropsychologist." He would personally rely on three or four additional tests to corroborate a deficit. In Dr. Brooker's opinion, Dr. Roeder should have administered other corroborative tests to respondent based on deficits identified in the LNNB, but failed to do so. This is particularly necessary where, for example, respondent scored "pretty high" on the Wechsler Memory Scale test, but demonstrated deficits on the LNNB (i.e., in Intermediate Memory). This same inconsistency was demonstrated in the stark contrast between respondent's WAIS results, both cumulatively and in its subtests, and his LNNB results. The Wechsler tests are highly regarded assessments and are considered more reliable than the LNNB. The disparity in respondent's Wechsler and LNNB test results should have resulted in corroborative testing.

In Dr. Brooker's opinion, Dr. Roeder's neuropsychological report is invalid based on his use of the LNNB, the disparity in respondent's test results on both Wechsler tests and the LNNB results, and Dr. Roeder's failure to corroborate negative findings on the LNNB. Dr. Brooker also testified that the LNNB, if utilized, should be administered by an experienced neuropsychologist and not by a psychological assistant. In his opinion, it was an ethical violation for Dr. Roeder to use a psychological assistant who was not registered with the Board of Psychology to administer the tests.²³

125. *Dr. Roeder's Rebuttal Testimony:* Dr. Roeder is familiar with and respects Dr. Brooker. In response to Dr. Brooker's testimony challenging the LNNB's validity, Dr. Roeder denied that it was "obsolete" and testified that there are "thousands" of references to the LNNB on the internet. To demonstrate this, Dr. Roeder provided copies of the following documents: an abstract of a 1997 study from the *Indian Journal of Psychiatry* (Nizamie, et al., "Comparative Study of Clinical Effectiveness of Luria Nebraska Neuropsychological Battery, EEG and CT scan in Brain Damaged Patients"); a print-out from the University of California, Davis Alzheimer's Disease Research Center (ADC), providing a list of "some of the tests that are administered at the ADC," including the LNNB; and excerpts from the *Buros Center for Testing* ("Test Reviews: Luria Nebraska Neuropsychological Battery: Forms I and II) including two 1992 reviews. Dr. Roeder testified that *Buros* produces the *Mental Measurements Yearbook*, a compendium of psychological tests which is a primary reference for psychologists. *Buros* reported that the LNNB's primary strength is its ability to identify brain damage, and that reliance on computer scoring and a computerized report was its weakness. Because Dr. Roeder agrees with the criticism about using the computer report, he did not include it in his report. The computer-generated report for respondent said that he had three of the five general indications of impaired brain functioning at a significant level, which showed that there was a 75 percent likelihood of significant brain impairment. Other than the internet printout, Dr. Roeder had no personal knowledge of test batteries used at UC Davis ADC.

Dr. Roeder reviewed Dr. Lezak's discussion of the LNNB in the *Neuropsychological Assessment*. He agreed that this is a widely-used textbook in the field and testified that these were valid criticisms of the original LNNB, which came out in 1980. This test was then restandardized and reissued in the LNNB-II, which he used for respondent. In his opinion, this text did not address the instrument he administered. On further discussion, Dr. Roeder agreed he was not certain whether the discussion in the 2012 edition of *Neuropsychological Assessment* pertained to the LNNB-II or not.

126. The weight of the evidence establishes that the criticisms contained in the 2012 edition of "*Neuropsychological Assessment*" pertain to Form II of the LNNB. It was undisputed that this is a preeminent neuropsychological textbook relied on by the professional community throughout the United States. While its discussion does not

²³ The parties disputed whether Ms. Lawrence was a psychometrician or a psychological assistant. In light of the conclusion reached, it is unnecessary to address this contention.

distinguish between Forms I and II, the subtitle to this chapter includes the dates 1985 and 1991 after the authors' names and a footnote refers to Form I with a parenthetical date of 1980.

The "Administration & Scoring Booklet" for the LNNB administered to respondent as part of Dr. Roeder's evaluation has a copyright date of 1984 by Western Psychological Services (WPS) and references Form II "as summarized in this booklet." In addition, Dr. Roeder's raw data for his assessment includes a computerized "LNNB Test Report," (Report) referencing the LNNB-Form II, with the most recent WPS copyright date of 1991 (Version 3.014).

127. The criticisms about the LNNB are much broader than the battery versus the hypothesis testing approach debate discussed by Dr. Roeder, and they extend beyond problems with reliance on computerized reports. As indicated in Dr. Brooker's testimony, the criticism extends to the basic reliability of the instrument. Dr. Brooker's testimony significantly undermines confidence in sole reliance on the LNNB results, particularly when such reliance would essentially terminate respondent's ability to continue practicing as a physician.

Moreover, Dr. Brooker's testimony is persuasive that the LNNB is of such a questionable nature that it cannot be the sole basis for a neuropsychological opinion that respondent is cognitively impaired and unsafe to practice medicine. As a Diplomate in Clinical Neuropsychology with extensive experience in the field, Dr. Brooker's opinion that any negative findings on the LNNB must be corroborated by additional neuropsychological testing is entitled to substantial weight. The need to perform corroborative testing is underscored by facts demonstrating respondent's positive test results on the Wechsler's IQ and memory tests, including in the specific areas that Dr. Roeder indicated are sensitive to showing general cognitive impairment (Factual Finding 115). Dr. Brooker's opinion also finds support in the LNNB's own Report which expressly cautions that "...the LNNB should never be used simplistically or in isolation. The hypotheses suggested by the test should be corroborated by other methods, including clinical interviews, behavioral observations, detailed clinical history, *and other neurodiagnostic procedures.*" (Italics supplied.)

128. No expert testimony was provided by which it would be possible to select out certain of the tests administered by Dr. Froming and use them to corroborate Dr. Roeder's LNNB-II findings.

129. *Dr. Hammel's Neuropsychological Evaluation:* In addition to the professional opinions described above, Dr. Hammel conducted an eight-hour clinical observation and interview of respondent on May 19, 2011, at respondent's office. Additional relevant observations and opinions are described below.

130. During his clinical interview and observations of respondent, Dr. Hammel noted that respondent had consistent affect and mood, with no indications of anger, mood swings, impulsivity or paranoia. Respondent had good insight, with a capacity for self-

criticism and humor; he was able to provide examples of tasks he engaged in that were “at variance with the capacities of an individual with a broken or impaired brain.”

131. Regarding respondent’s successful performance in the PACE programs, Dr. Hammel characterized respondent’s poor performance on the Microcog as an anomaly, based on respondent’s report that he “ran out of time and was not able to complete this computer-based test.” Respondent’s failure to complete the test reflected his deliberative test-taking behaviors. Respondent’s explanation that he ran out of time was consistent with the fact that his “poor Microcog test results appeared to be consistent across the board” without peaks and valleys showing strengths and weaknesses. Dr. Hammel opined that respondent’s “poor Microcog test performance is not the common profile of an individual suffering from a brain injury or late-life intellectual deficit.”

132. As part of his evaluation, Dr. Hammel reviewed a post-surgical Operative Report written by respondent on May 17, 2011, the morning after he performed surgery on a 17-month-old boy who was brought into the emergency room after being bitten by a pit bull. The child had deep puncture wounds on his face and jaw. Respondent was called into the hospital to operate short before midnight. He began a lengthy surgery at 1:45 a.m. and then prepared the report. This surgery was performed over a month after Dr. Roeder’s evaluation. Dr. Hammel assessed the operative report from a neuropsychological perspective and found that respondent’s writing was “organized and logical,” his grammar was “normative” and vocabulary was “rich.” Respondent demonstrated “the capacity for both sustained concentration and mental flexibility. There is recall of both long-term and recently learned information.” The Operative Report showed “no evidence of a compromised or impaired brain.”

133. Based on his review of the medical and legal record and his clinical evaluation of respondent, Dr. Hammel’s opined that respondent does not possess clinically significant psychopathology, is cognitively intact and does not suffer from a diagnosable, disabling cognitive disorder. He noted that, “if the total picture of [respondent’s] relative cognitive strengths and weaknesses were honestly considered, it is equally valid to render the opinion that [respondent] was displaying normative individual and age-related test variations for a person with a presumed life-long high level of intellectual ability and professional attainment.” In Dr. Hammel’s opinion, respondent “possesses the cognitive capacity and requisite psychological health to safely engage in the practice of medicine and surgery.

134. *Criticisms of Dr. Hammel’s Evaluation and Opinions:* After reviewing Dr. Hammel’s evaluation, Dr. Roeder testified that it is not appropriately denominated a “neuropsychological evaluation” because Dr. Hammel did not administer any testing to respondent. A standard neuropsychological evaluation involves neuropsychological testing. Respondent stipulated that Dr. Hammel did not perform any neuropsychological testing. Dr. Roeder also found certain of Dr. Hammel’s opinions not to be reasonable.

135. OTHER EVIDENCE OF RESPONDENT’S POSITIVE COGNITIVE FUNCTIONING: In addition to his successful completion of the PACE Program over a

period of approximately 56 hours, respondent offered other non-expert evidence of his intact cognitive functioning. This included testimony from Oroville Hospital's Chief Executive Officer (CEO) Robert Wentz, declarations from doctors and nurses who have known and worked with respondent in his capacity as a surgeon, and testimony about several surgeries which he performed during the times of his neuropsychological evaluations which demonstrated his ability to practice medicine safely, including that described in Factual Finding 132.

136. *Testimony of Robert Wentz:* Mr. Wentz has been the President and CEO for Oro Health Corporation and the Oroville Hospital since the late 1980s. Oroville is a 153-bed hospital, which has approximately 30 surgeons practicing a variety of specialties including neurology, oncology, plastic surgery/maxillo facial, orthogenetic surgery. He has known respondent in a professional capacity since 1983, when they both worked at Chico Community Hospital, which became the Enloe Medical Center.²⁴

Mr. Wentz testified that respondent was elected to and completed a one-year position as Oroville's Chief of Surgery beginning in December 2010. Respondent was nominated for the position by Oroville's director of anesthesia, Dr. Osifo, and was unanimously elected by a vote of his peers, including the chief of surgery, chief of nursing, and chief operating officer. The chief of surgery and other surgeons were aware of respondent's Board probation.

As chief of surgery, respondent was required to prepare agendas and chair meetings on various topics. Mr. Wentz indicated that, in his experience, surgeons tended to have more acrimonious or adversarial types of discussions. As chairman of these meetings, respondent was required to keep the discussions on track. In Mr. Wentz's observation, respondent "ran a very good meeting" and he "never received any complaints from any of the members that they were not able to assert their position." During these meetings, respondent was required to multi-task, and he did this well.

In his role as chief of surgery, respondent was also a member of various committees, including the hospital's mortality and morbidity committee. The mortality and morbidity committee focused on peer case review, primarily of surgical cases that were either high frequency or problem prone. Members had frank discussions of surgical issues to improve performance. Mr. Wentz, who was also a member of this committee, described respondent as "a valuable member" who gave good comments.

²⁴ Mr. Wentz testified that he was aware respondent had lost privileges at Enloe; respondent was very transparent about these issues and his Board probation.

Mr. Wentz testified that the hospital was provided with the Board's petition for ex parte ISO sometime after May of 2011, with the neuropsychological reports.²⁵ As Oroville's CEO, Mr. Wentz is responsible for having processes in place to ensure that its doctors are clinically competent. He was aware of the Board's allegation that respondent was cognitively impaired and could not safely practice medicine. He spoke to respondent, who was forthcoming and who agreed to suspend performing surgery pending an internal review. Mr. Wentz began an internal investigation to determine "whether or not we believed that Dr. Morgan is currently clinically competent." This was done by a retrospective review of respondent's surgical cases and by discussing his performance with medical personnel who had observed respondent operate. For example, the emergency room doctor on call on May 17, 2011 reported being "very impressed" with respondent's work, which saved the child from disfigurement. (see, Factual Finding 132.) Mr. Wentz indicated that, because surgery can be very procedural, they examined whether respondent was "forgetting" or "skipping" things during surgery. They found no evidence of that. Respondent's surgical outcomes were good, within normal range, and there was no evidence of substance abuse. No neuropsychological tests were administered to respondent as part of this investigation.

After completing a retrospective review, the hospital performed a concurrent review by assigning various surgeons to proctor respondent. Mr. Wentz testified that, at the end of that investigation, they found no evidence that respondent was cognitively impaired or that he acted in an emotionally inappropriate manner. Mr. Wentz indicated that there was evidence that respondent "did not do his charts as rapidly as we would like him to do," but that this was not atypical among their surgeons. Mr. Wentz received other complaints about respondent, specifically, that he "sometimes wants to hurry the nurses along," which is upsetting to them. Since 2011, respondent has had malpractice suits but not to any greater degree than any other surgeon, particularly in a cosmetic practice.

Mr. Wentz also testified that respondent appears excited about practicing medicine. Respondent is one of the doctors who consistently brings current literature and information about innovations in his field to Mr. Wentz's attention, particularly in areas he believes the hospital might or should become involved (e.g., cleft palate, tissue banking). Respondent is required to be recredentialed at Oroville every two years and has done so.

137. *Respondent's Testimony*: Respondent was present throughout the hearing. He testified coherently and at length over multiple days (one full day and two partial days). He described the components of his extensive career, which has included military service, academic appointments and many years as a volunteer with Northern California Cleft Palate Panel. Respondent currently works at his facility approximately 50 hours a week. He sees patients in the morning and performs surgery in the afternoon. Respondent estimated that he performs 10 to 15 surgeries a week. In 2012, respondent performed 298 surgeries. Respondent did not articulate any plans to retire or otherwise curtail his practice.

²⁵ Mr. Wentz had some difficulty determining exactly which documents he remembered reviewing, but he clearly recalled the substance of the concerns raised in the Petition for ISO and supporting evaluations.

Respondent's demeanor was appropriate, professional, without indications of anger or resentment. Respondent demonstrated confusion and nervousness in certain instances, for example, in locating documents from among multiple binders. His confusion was slightly more obvious than with other witnesses who also required occasional assistance. At the end his testimony, in response to the undersigned's question, respondent misunderstood the question and exhibited some defensiveness by providing an extensive narrative explaining his behavior over the years of assessments. Respondent then acknowledged the Board's concern about impaired physicians, but stated he does not believe that the evidence demonstrates his impairment to safely practice.

138. Respondent also offered declarations from medical professionals about his abilities as a physician and surgeon. These declarations, submitted in May 2011 in opposition to the Petition for ISO, are from registered nurse first assistant (RNFA) Diane Kindred; Ross W. Tye, M.D., Ph.D.; Charles B. Reiman, M.D; Dewayne Caviness, M.D., and Mark G. Womack, DDS. They are extensively summarized in the June 9, 2011 Ruling on Petition for ISO. Ms. Kindred, Dr. Reiman, and Dr. Caviness have observed respondent perform multiple surgeries and laud his skills. Other declarants have referred patients and/or family members to respondent for surgery with positive results. In addition, Dr. Tye and respondent are both private pilots. Dr. Tye has observed respondent's piloting skills and expressed his comfort in respondent's flying judgment and abilities.

139. Respondent has complied with the conditions of his probation. Since completing the PACE program, he has participated in a neurological evaluation and two neuropsychological evaluations. There was no evidence that, prior to the Petition for Ex Parte ISO, respondent was ever instructed to cease practicing medicine. Respondent testified that he did not learn of Dr. Roeder's evaluation until the ISO Petition was filed. He then exercised his due process rights to challenge those results. Respondent did not cause delay in bringing this matter to hearing.

140. *Discussion:* The determination of whether respondent suffers from cognitive impairment to an extent that renders him unsafe to practice medicine is difficult. While the Board obtained two neuropsychological evaluations to this effect, significant persuasive challenges to the validity of and/or weight to be given to these reports were raised. The decision-making process was hampered by Dr. Froming's failure to testify. While respondent's specific challenges to Dr. Froming's report and her conclusions were known well in advance of the hearing, no expert testimony was offered, either from Dr. Froming or from any other expert, to address them. Dr. Roeder provided thoughtful testimony about the strengths and weaknesses of his report. Nonetheless, there was insufficient clear and convincing evidence that the LNNB, considered alone, was a sufficient basis upon which to conclude that respondent indeed suffers from cognitive impairment to an extent that renders him unsafe to practice medicine, rather than from relative weaknesses within an overall average to superior landscape. No expert testimony was elicited about whether any of Dr. Froming's test results could be used to corroborate Dr. Roeder's LNNB results. In this regard, there were curious inconsistencies between these reports. For example, on the

WMS-IV, Dr. Froming noted respondent's relative weakness in visual memory using both sets of norms, as well as his "relatively preserved Verbal Memory function." By contrast, on the WMS-R, Dr. Roeder found respondent's visual memory index to be 122 (his second highest score) compared to his verbal memory at 109 (his lowest score). Both reports reflect an individual who has great cognitive strengths as well as weaknesses. Respondent's reported weaknesses, using age-appropriate norms, are in the average range.

While it is hoped that all physicians and surgeons are above average in all areas throughout their careers, there was no competent expert testimony that this is the standard for all licensees. The Medical Practice Act does not provide an upper age limit for practicing physicians and surgeons. Ultimately, concerns for public safety cannot be a substitute for the clear and convincing evidence necessary to reach a conclusion that effectively terminates a career. There was insufficient evidence to establish that respondent is incapable of practicing medicine safely within the meaning of section 822. There were no allegations of specific cases to support a finding of incompetence within the meaning of section 2234, subdivision (d). For these reasons and those set forth in Factual Finding 139, there is no basis to revoke respondent's probation.

141. *Summary:* Respondent's probation was scheduled to terminate in October 2013, which was stayed pending resolution of this issue. For the reasons set forth in Factual Finding 140, his license is fully restored. For the reasons set forth in Factual Findings 25 through 75, respondent's license is revoked; however, revocation is stayed and he is placed on probation for five years, subject to conditions outlined below.

LEGAL CONCLUSIONS

1. *Burden and Standard of Proof on Accusation:* In this action to suspend or revoke respondent's license based upon the allegations in the First Amended Accusation, complainant has the burden of proof by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

2. *Burden and Standard of Proof on Petition to Revoke Probation:* On a petition to revoke probation, complainant has the burden to establish the facts underlying the revocation; however, complainant is only required to prove the allegations in a petition to revoke probation by a preponderance of the evidence. (*Sandarg v. Dental Board* (2010) 184 Cal.App.4th 1434, 1441; Evid. Code, § 115.)

3. *Purpose of Physician Discipline:* The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Disciplinary proceedings protect the public from incompetent practitioners by eliminating those individuals from the roster of state-licensed professionals. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

4. Section 822 provides:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

5. Pursuant to section 2234, the Board "shall take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct described in section 2234 includes, but is not limited to, the following:

[¶] . . . [¶]

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

[¶] . . . [¶]

6. Pursuant to section 2266, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. As set forth in the Factual Findings and Legal Conclusions as a whole and particularly, in Factual Findings 76 through 140, it was not established by clear and convincing evidence that respondent's ability to practice medicine is impaired because he is mentally or physically ill affecting competency, within the meaning of section 822. There were no allegations of specific conduct by respondent constituting incompetence within the meaning of section 2234, subdivision (d).

8. As set forth in the Factual Findings and Legal Conclusions as a whole and particularly, in Factual Findings 139 through 141, it was not established by a preponderance of evidence that respondent's probation in Case No. 16 2002 132501 (OAH Case No. 2008010402) should be revoked.

9. As set forth in the Factual Findings and Legal Conclusions as a whole and particularly, in Factual Findings 25 through 35, it was established by clear and convincing evidence that respondent engaged in repeated negligent acts by his conduct of administering Propofol to patients at his ambulatory surgery center.

10. As set forth in the Factual Findings and Legal Conclusions as a whole and particularly, in Factual Findings 36 through 45, it was established by clear and convincing evidence that respondent failed to maintain adequate and accurate records within the meaning of section 2266.

11. As set forth in the Factual Findings and Legal Conclusions as a whole and particularly, in Factual Findings 46 through 47, it was established by clear and convincing

evidence that respondent engaged in gross negligence by his conduct of interfering with emergency medical personnel on January 11, 2012, resulting in delay in patient transport.

12. As set forth in the Factual Findings and Legal Conclusions as a whole, probation is appropriate.

ORDER

I. The Petition for Revocation of Physician's and Surgeon's Certificate No. C23681 issued to respondent Loren Morgan, M.D., is DENIED, pursuant to Legal Conclusions 7 and 8. Based on respondent's completion of probation in Case No. 16 2002 132501 (OAH Case No. 2008010402), this Certificate is fully restored.

II. Physician's and Surgeon's Certificate No. C23681 issued to respondent Loren Morgan, M.D., is REVOKED pursuant to Legal Conclusions 9, 10, and 11. However, revocation is STAYED and respondent is placed on probation for five (5) years upon the following terms and conditions.

1. *Education Course (Condition 13):* Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. *Medical Record Keeping Course (Condition 15):* Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. *Notification:* Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. *Supervision of Physician Assistants:* During probation, respondent is prohibited from supervising physician assistants.

5. *Obey All Laws:* Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. *Quarterly Declarations:* Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. *General Probation Requirements:*

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes: Respondent shall, at all times, keep the Board informed of his business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its

designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in Respondent's or a patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. *Interview with the Board or its Designee:* Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. *Non-practice While on Probation:* Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

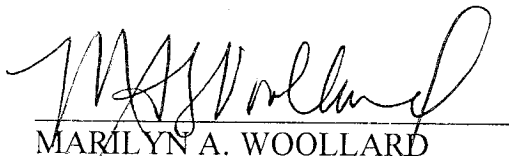
10. *Completion of Probation:* Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. *Violation of Probation:* Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. *License Surrender:* Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. *Probation Monitoring Costs:* Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: March 18, 2014


MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings